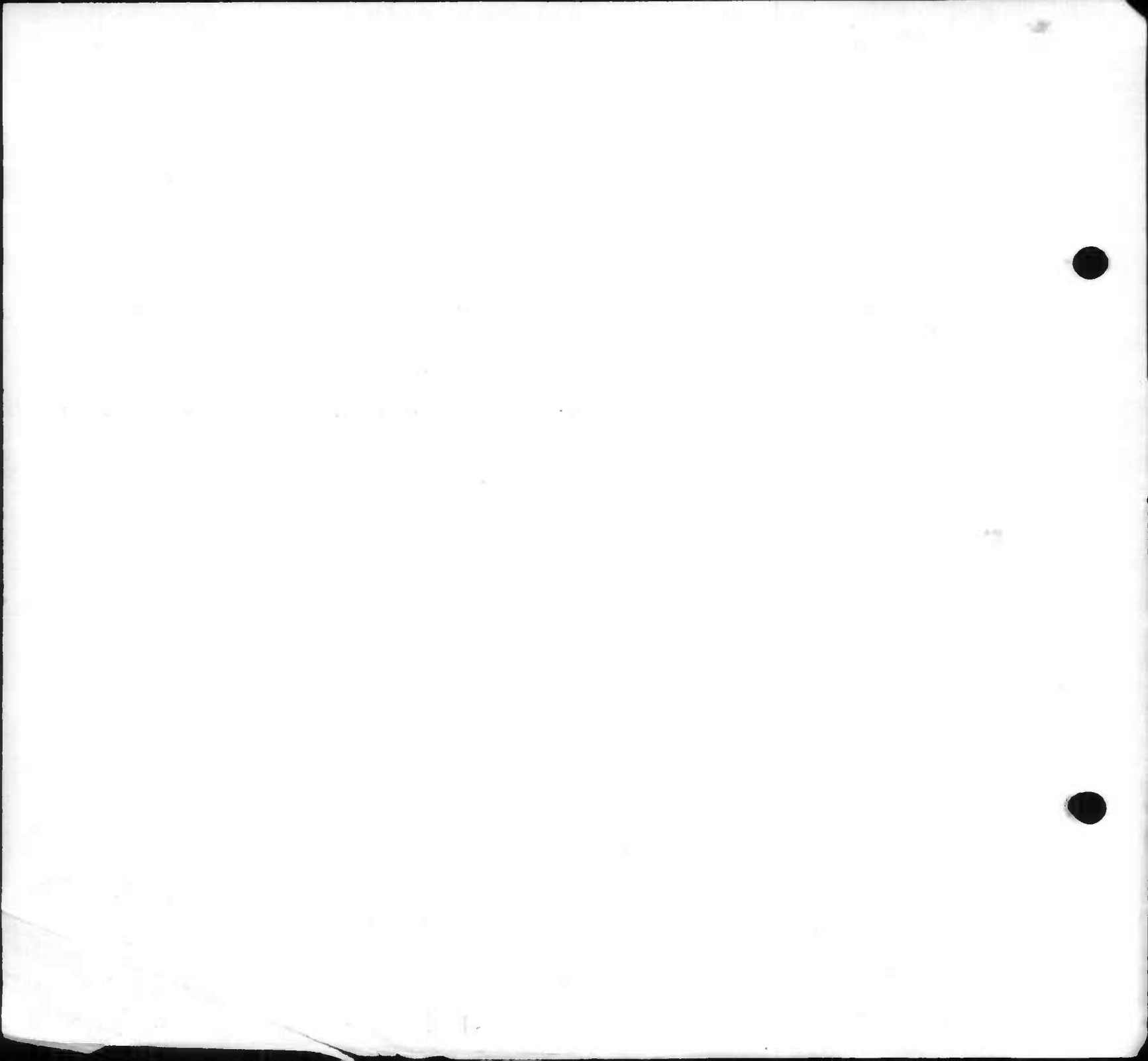


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

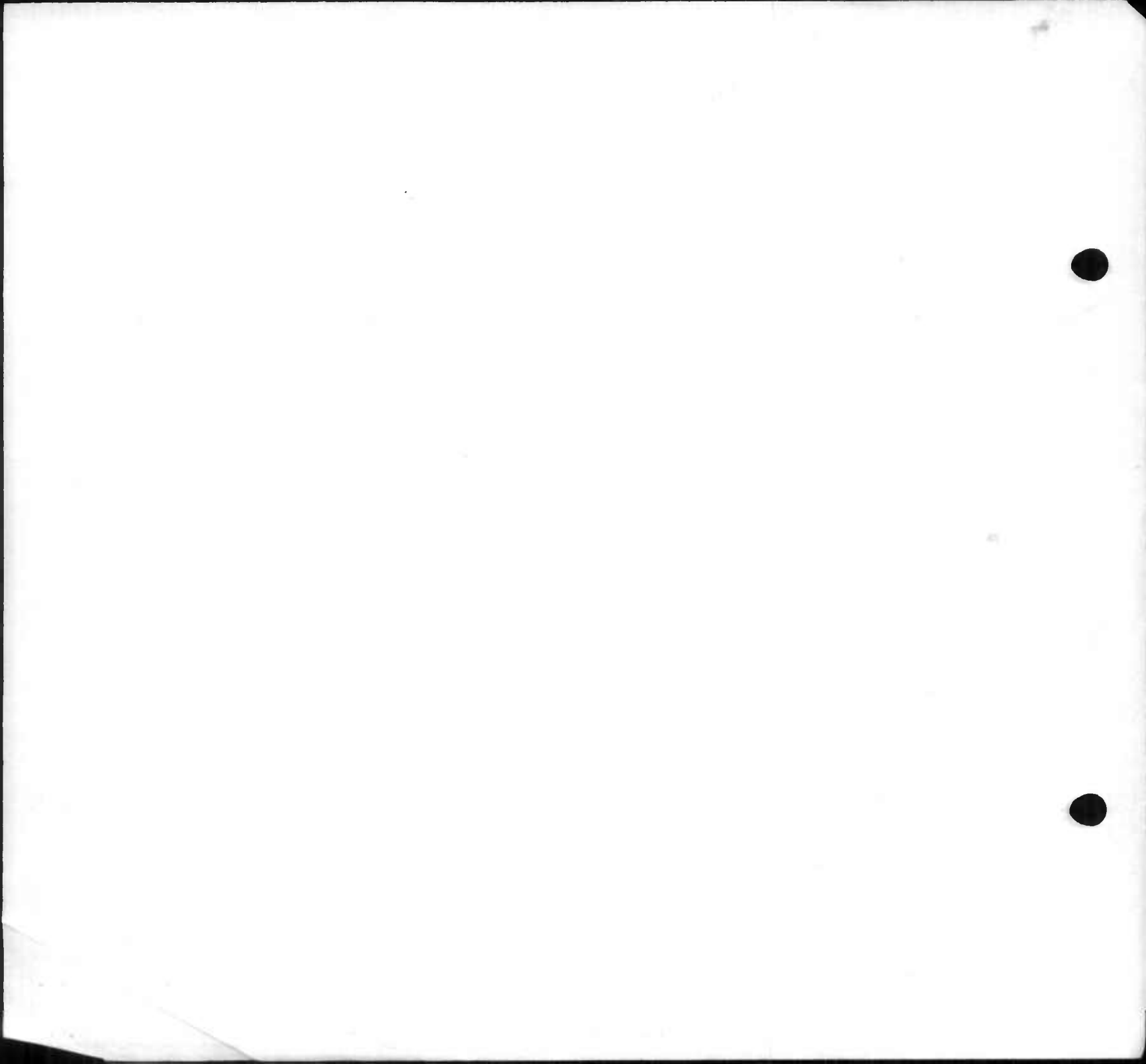
BIRTH NO. 71 8501		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8501	
1. NAME OF DECEASED (Type or Print) CHRISTIAN Mrs. ELLA B.			2. DATE AND HOUR OF DEATH SEP 9th 1971 3:40A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MD. GEN. HOSP.			A. STATE MD. B. COUNTY 1205		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1701 GUILFORD AVE.		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2.3.13	9. AGE (in years last birthday) 58.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.
13. FATHER'S NAME PETER MC CAIN			14. MOTHER'S MAIDEN NAME LELIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 225-41-1636		17. INFORMANT HERMAN CHRISTIAN 1701 GUILFORD AV
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Anterolaryngeal & CARDIAC FAILURE.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA ESOPHAGUS.		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION SEP 7th 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. ESOPHAGUS.		20A. AUTOPSY? (Yes or No) YAE	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8.25.1971 to 9.9.1971 that (I) (we) last saw the deceased alive on 9.9.1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED SEP. 9th 1971	
23C. PHYSICIAN'S NAME (Type) H. S. LANGAN 17H MD				23D. ADDRESS MD. Gen. Hosp. Balto. md 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 9-13-71	24C. NAME OF CEMETERY or CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971		25B. NAME OF REGISTRAR JAMES E. [Signature]		25C. FUNERAL DIRECTOR CHARLES M. RICE	
				ADDRESS 661 W. 13th ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

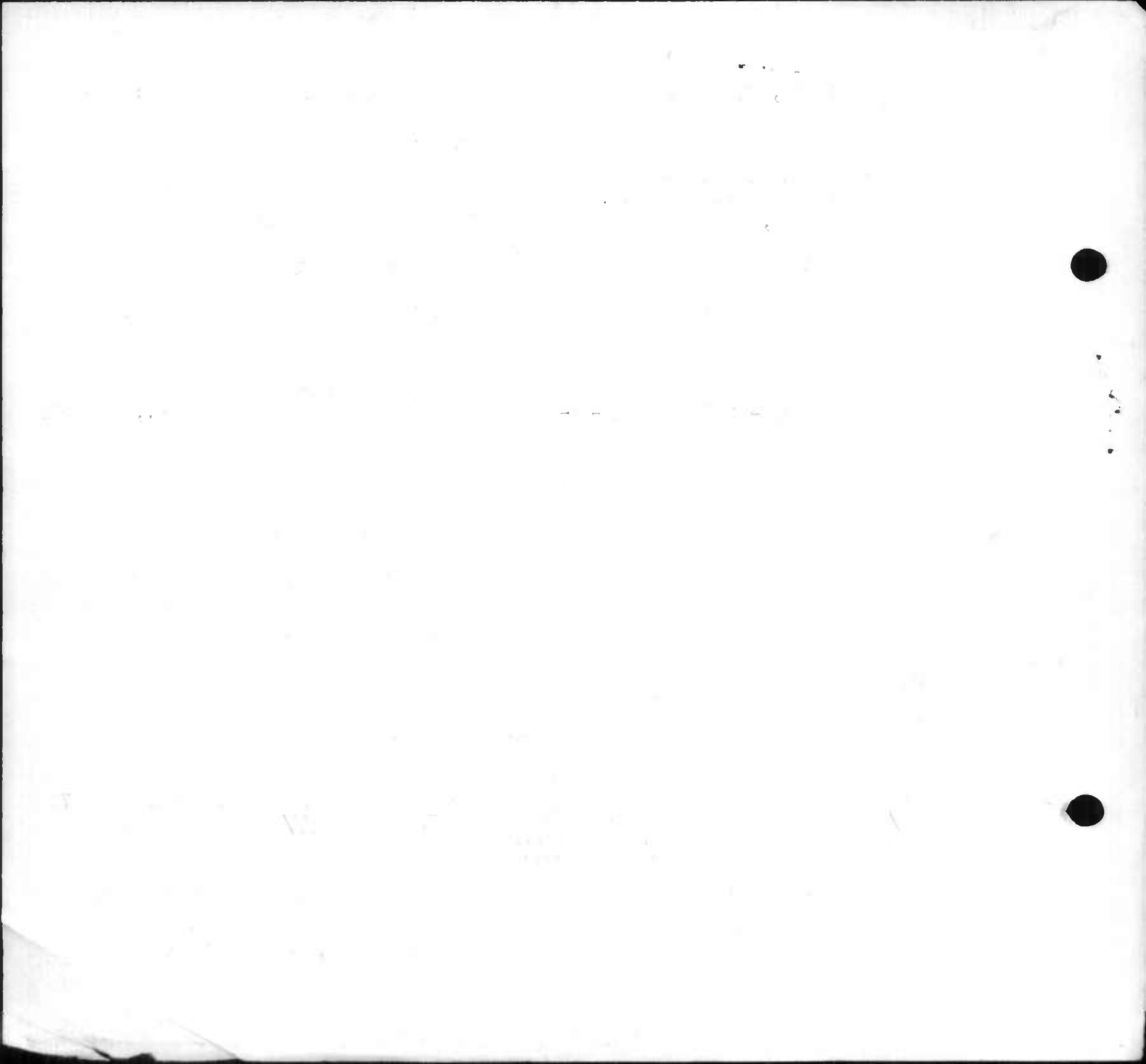
BIRTH NO. 71 8502		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8502	
1. NAME OF DECEASED (Type or Print) TROY SIGGS -			2. DATE AND HOUR OF DEATH 9-7-71 - 3:45 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC. -			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1513		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2418 OSWEGO AVE, 21215		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-29	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Morven, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lester Diggs			14. MOTHER'S MAIDEN NAME Clara Diggs		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 244-34-0967		17. INFORMANT Haizlip Funeral Home
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATIC COMA HEPATO-RENAL (B) CIRRHOSIS OF THE LIVER DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC ALCOHOLISM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 10 Y 20 Y
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-20 19 71 to 9-7 19 71 that (I) (we) last saw the deceased alive on 9-7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE GUTIERREZ MD.			23B. DATE SIGNED 9-7-71		23C. PHYSICIAN'S NAME (Type) FELIX GUTIERREZ MD.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-11-71		24C. NAME of CEMETERY or CREMATORY Mt. Olivet
24D. LOCATION Thomasville, N.C.			25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971		
25B. NAME OF REGISTRAR Robert E. Jolley, M.D.			25C. FUNERAL DIRECTOR Haizlip Funeral Home		
VS 150-REV. 1/1/68			N.C.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

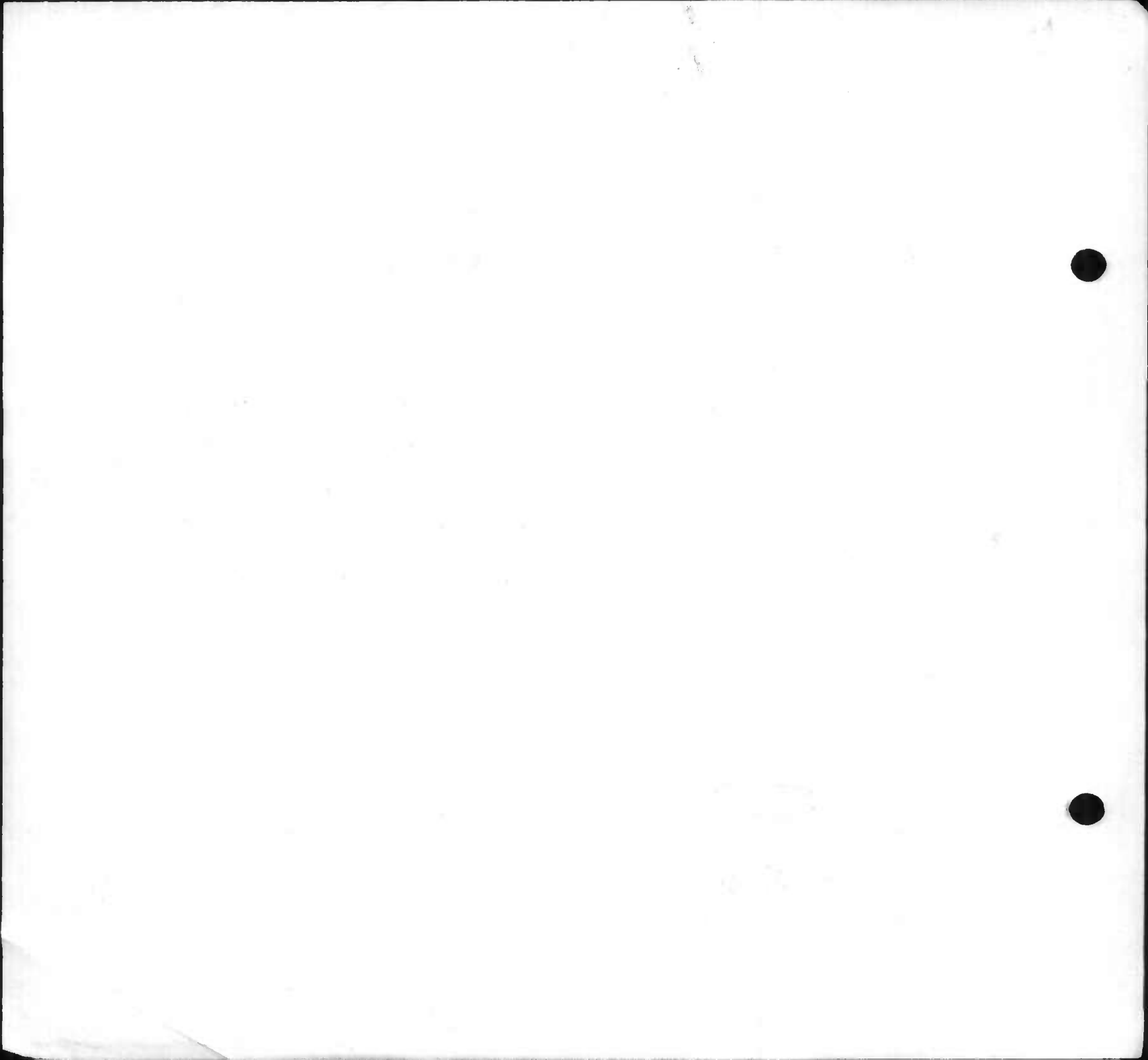
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>8503</u>	
BIRTH NO. <u>71</u> <u>8503</u>				1. NAME OF DECEASED (Type or Print) <u>CUTLER, Ely Moses</u>		2. DATE AND HOUR OF DEATH <u>8/26/71</u> <u>8:25 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>902</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3900 Loch Raven Boulevard</u>							
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/89</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>7/23/18 - 11/14/18</u>			16. SOCIAL SECURITY NO. <u>212-54-3086T</u>		17. INFORMANT <u>VA Hospital Records</u> <u>3900 Loch Raven Boulevard Balto., Md 21218</u>		
18. <u>E917X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <u>CEREBRAL ANOXIA</u>		<u>5 HRS</u>	
				DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PULMONARY INSUFFICIENCY</u>		<u>24 HRS</u>	
				(C) <u>BILOBAR PNEUMONIA</u>		<u>9 DAYS</u>	
				<u>SUBCAPITAL FRACTURE LEFT FEMUR</u>		<u>21 DAYS</u>	
				<u>WITH INFECTED HIP PROSTHESIS</u>			
19A. DATE OF OPERATION <u>8/19/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INFECTED HIP PROSTHESIS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		21C. WHERE DID INJURY OCCUR? <u>Long Point</u> <u>62-00</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>7-23-71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fell (hit by wheel chair)</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>July 23rd</u> 19 <u>71</u> to <u>August 26th</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>August 26th</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>AW March MD</u>				23B. DATE SIGNED <u>8/26/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALLAN W. MARCH</u>				23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>CULPEPPER NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>CULPEPPER</u> <u>VA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frederick J. Cook</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

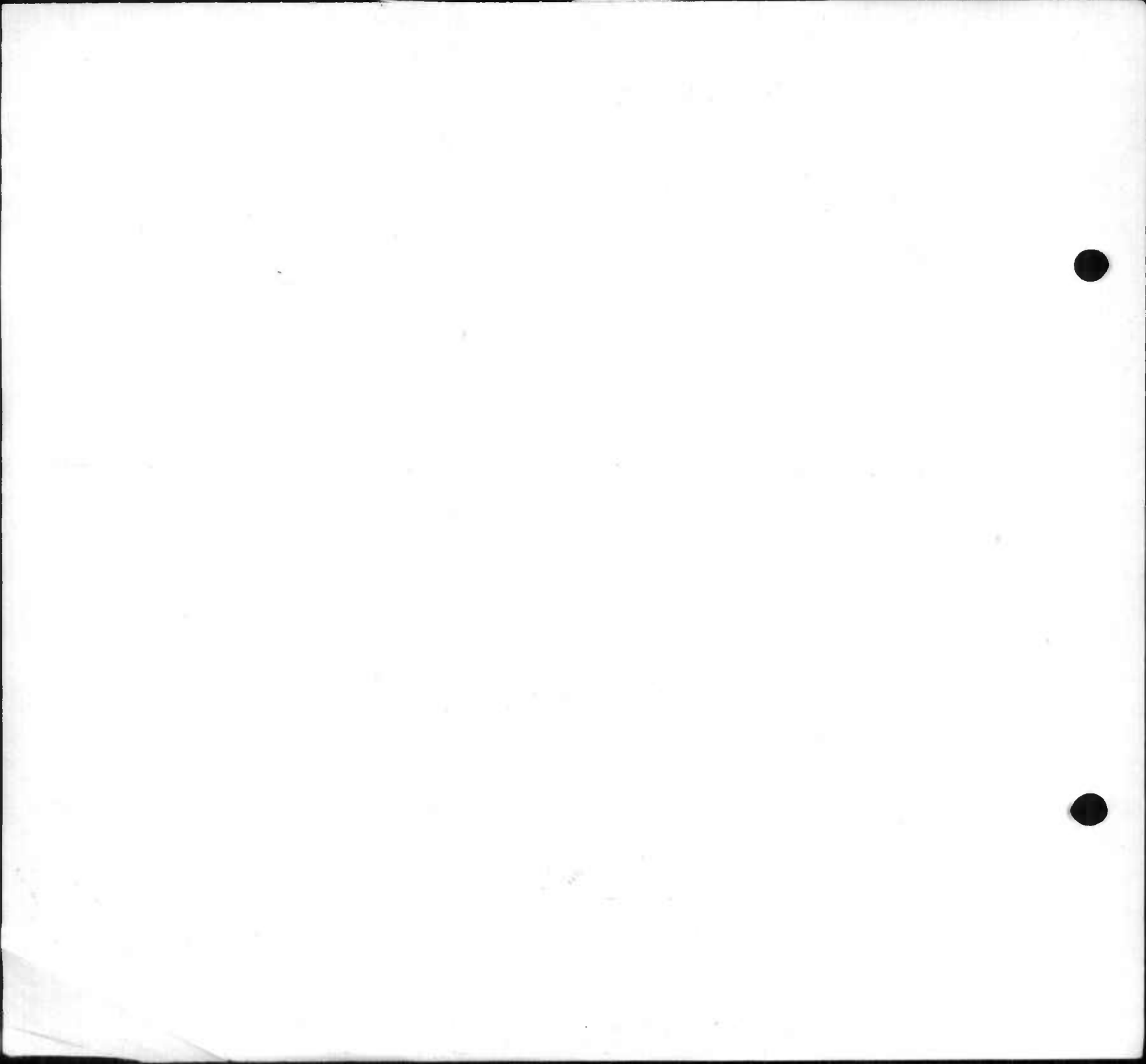
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>8504</u>	
BIRTH NO. <u>71</u> <u>8504</u>					
1. NAME OF DECEASED (Type or Print) <u>HENRY FINCHER (WALTER DAVIS)</u>			2. DATE AND HOUR OF DEATH <u>9-8-71</u> <u>1225</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2843</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 PROVIDENT</u> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2815 HILLSDALE RD</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1900</u>	9. AGE (in years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Boston Metal</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
13. FATHER'S NAME <u>William E. Davis</u>			14. MOTHER'S MAIDEN NAME <u>Laura ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>409-12-2745</u>		17. INFORMANT ADDRESS <u>Mr. William Davis 4102 Penhurst Avenue</u>	
18. <u>303.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>LIVER DISEASE</u> <u>CHRONIC ALCOHOLISM</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 YRS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD, SKIN ULCERS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC ALCOHOLISM</u> (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8-3</u> 19 <u>71</u> to <u>9-8</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9-3-</u> 19 <u>71</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jeff Parker, MD</u>			23B. DATE SIGNED <u>9-8-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Jeff Parker, MD</u>			23D. ADDRESS <u>2300 GARRISON BLVD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-11-1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. (City, town, or county)		24F. (State) <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NOTTER FUNERAL HOME 3035 W. NORTH AVE.</u>	



FUNERAL DIRECTOR: IMPORTANT

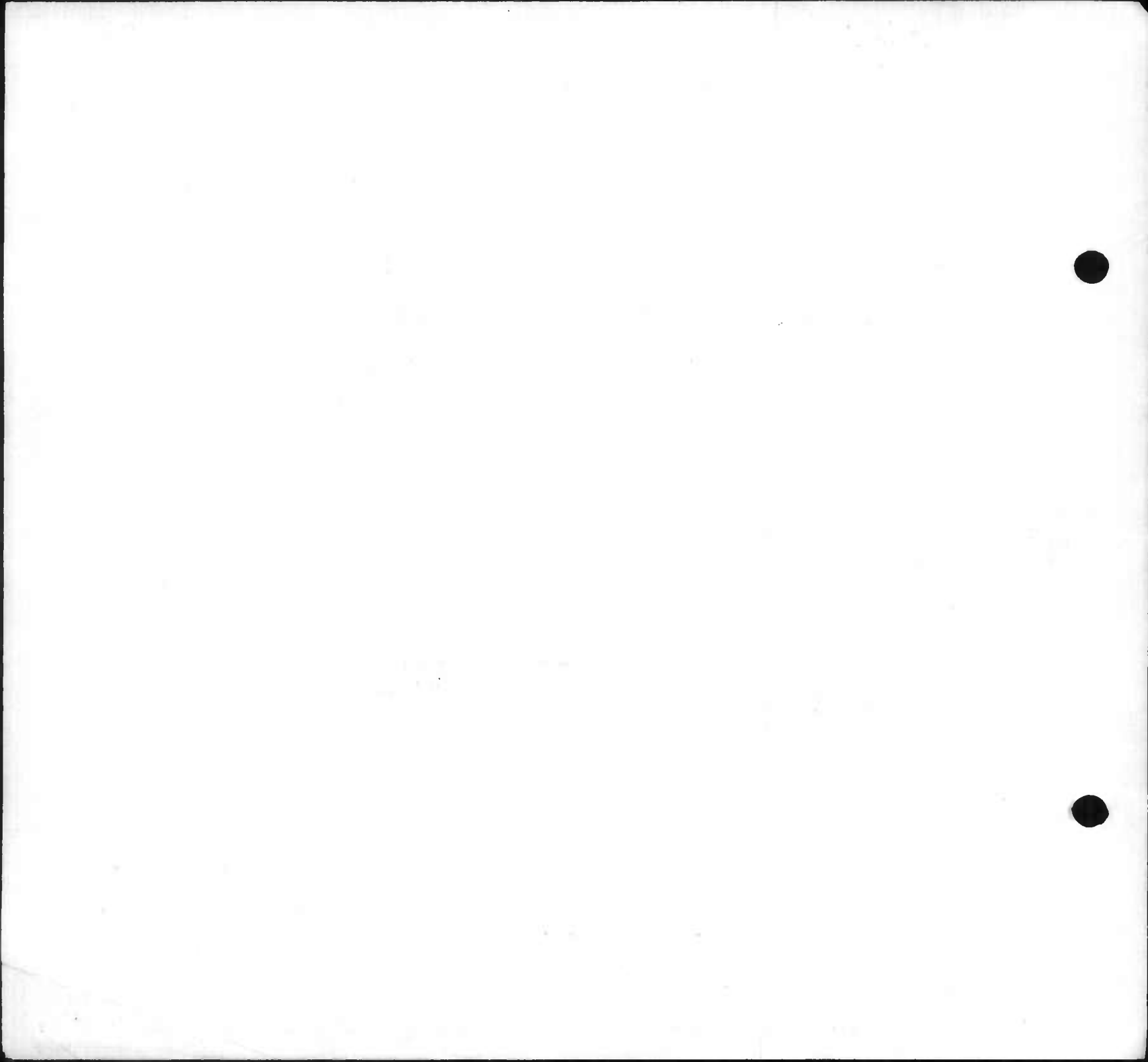
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8505	
CERTIFICATE OF DEATH					
BIRTH NO. 71 8505		1. NAME OF DECEASED (Type or Print) SHERIFF, MAEVEINA		2. DATE AND HOUR OF DEATH 9-2-71 10:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MD. B. COUNTY 1504		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1927 PULASKI ST.		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-28	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 5621 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Peritonitis secondary to perforated diverticuli. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			aneurysms of internal carotid and post. communicating artery		
19A. DATE OF OPERATION 7-30-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED central aneurysm		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that N (this hospital) attended the deceased from 6-27-71 to 9-2-71 that N (we) last saw the deceased alive on 9-2-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. N (We) (did not) view the body after death.					
23A. SIGNATURE Michael P. Buchness M.D.			23B. DATE SIGNED 9-2-71		23C. PHYSICIAN'S NAME (Type) Michael P. Buchness
24A. BURIAL CREMATION, REMOVAL (Specify) 9/11/71			24B. DATE		24C. NAME OF CEMETERY or CREMATORY BALTIMORE
24D. LOCATION BALTIMORE			24E. CITY, TOWN, or county (State)		24F. ADDRESS 2127 N. W. 10th Ave
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR W. B. CARROLL	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

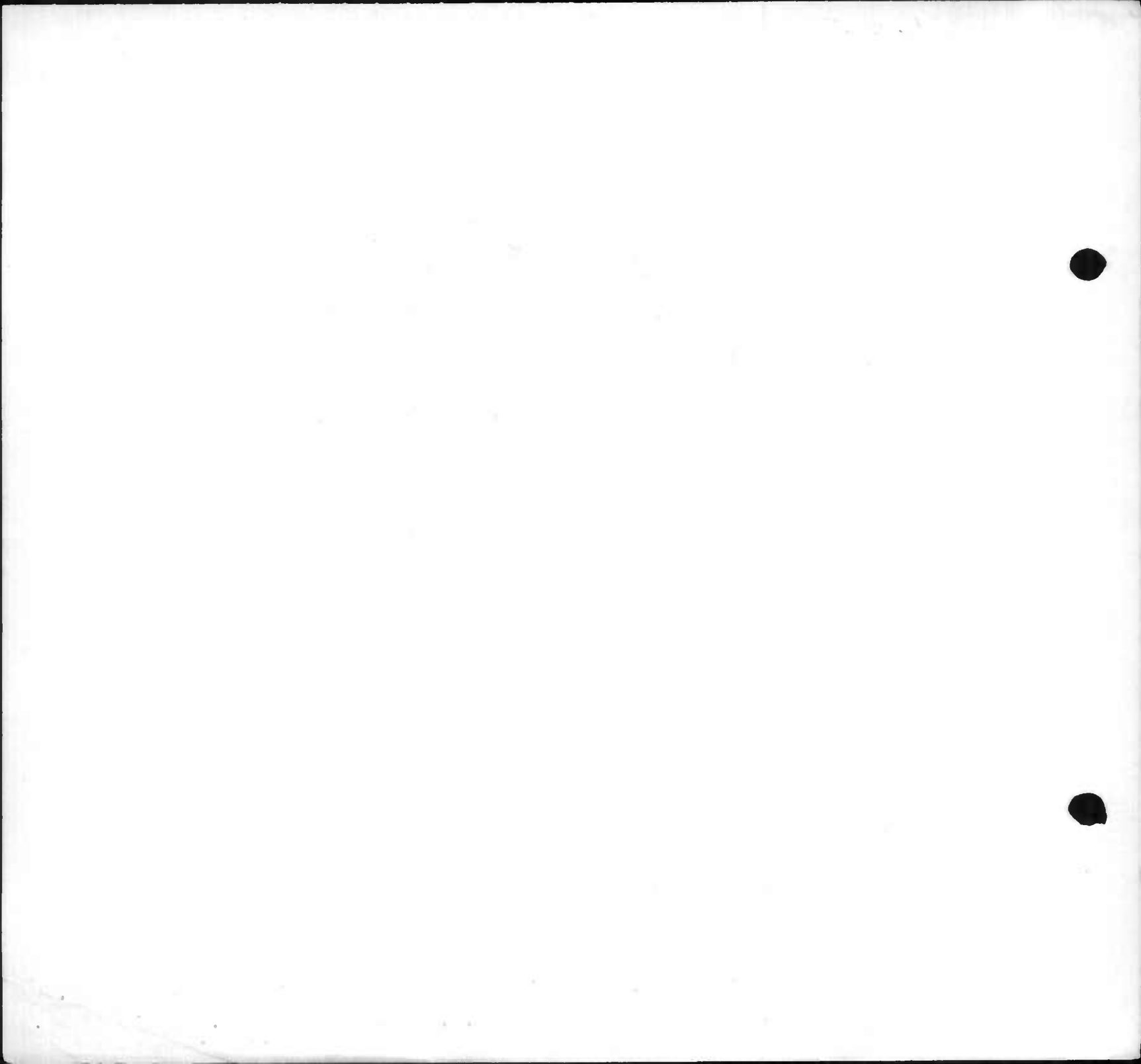
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>8506</u>	
BIRTH NO. <u>71</u> <u>8506</u>		1. NAME OF DECEASED (Type or Print) <u>LENOCH, MARY</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>9-6-71</u> <u>11:15 A</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>703</u>			
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/92</u> 9. AGE (In years last birthday) <u>79</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>315-05-8124</u>		17. INFORMANT ADDRESS <u>Joseph J. Lench 962 N. Collington Ave.</u>	
18. <u>347.9 H 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Aspiration Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Toxic Brain Damage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>UNKNOWN</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPTIC (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-2-71</u> 19 <u>71</u> to <u>9-6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James F. Martin</u>		23B. DATE SIGNED <u>9-6-71</u>		23C. PHYSICIAN'S NAME (Type) <u>JAMES F. MARTIN M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-9-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Anthony J. Quach</u>	
25D. ADDRESS <u>1211 Chesapeake Ave.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

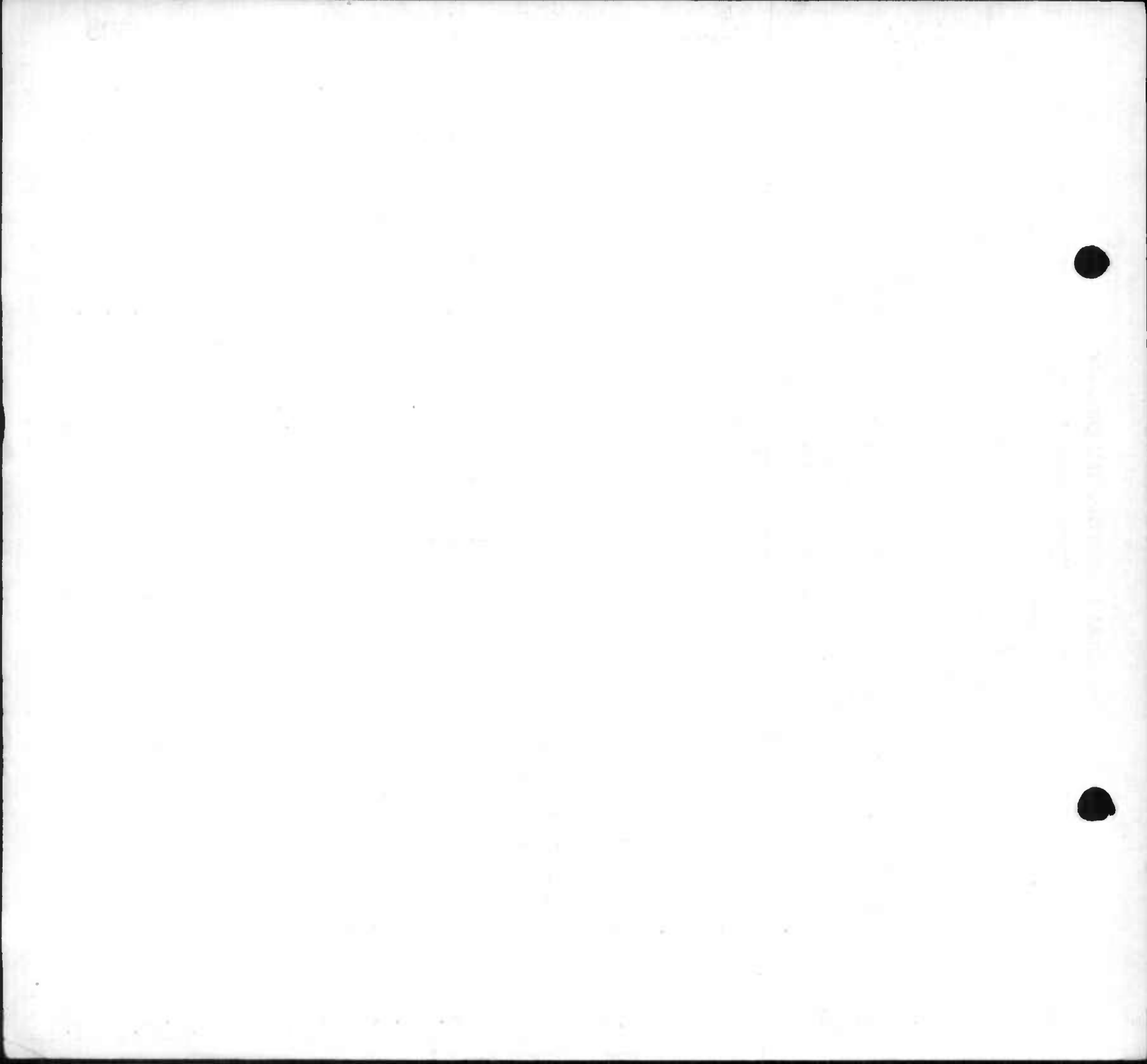
C-265		71 8507		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X		REG. NO. 71 8507		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cochran, MAY C.</i>				2. DATE AND HOUR OF DEATH <i>9/8/71 4 P.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNION MEMORIAL HOSPITAL</i>				C. CITY OR TOWN <i>OWINGS MILLS</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>530</i>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>GARRISON FOREST ROAD</i>						
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-15-29</i>		9. AGE (In years last birthday) <i>42</i>	10. Under 1 Yr. Months <i>1</i>		10. Under 24 Hrs. Days <i>1</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>REGISTERED NURSE</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>NURSING</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>PEYTONS. COCHRAN</i>				14. MOTHER'S MAIDEN NAME <i>MAY CURTIN</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>212-28-1542</i>		17. INFORMANT <i>PEYTON S. COCHRAN, JR</i>				ADDRESS	
18. <i>569-91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>APPOLOCEMIC SHOCK</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>GI BLEEDING</i> DUE TO, OR AS A CONSEQUENCE OF:						
				(C) <i>DREMITA</i>		<i>1 MONTH</i>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the hospital) attended the deceased from <i>9/2/71</i> 19 to <i>9/8/71</i> 19 that (I) last saw the deceased alive on <i>9/8/71</i> 19 and that (in my) <i>(c)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(c)</i> (We) <i>(d)</i> (did not) view the body after death.										
23A. SIGNATURE <i>Ramon Del Busto</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/8/71</i>		
23C. PHYSICIAN'S NAME (Type) <i>RAMON DEL BUSTO MD</i>						23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/10/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Thomas</i>		24D. LOCATION (City, town, or county) (State) <i>Garrison Forest, Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1971</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			25C. FUNERAL DIRECTOR & ADDRESS <i>H. M. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</i>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8508</u>	
BIRTH NO. <u>W-460 71 8508</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Nona Inez Weaver</u>		2. DATE AND HOUR OF DEATH <u>Sept. 8, 1971</u> <u>11 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3803 Monterey Road</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>903</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3803 Monterey Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1887</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edverett Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Martha William</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-7353</u>		17. INFORMANT <u>Mrs. Lavinia W. Keagle</u> ADDRESS <u>Same</u>	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.U.D.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7ms.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/22/10</u> 19 <u>71</u> to <u>9/8/71</u> 19 <u>71</u> that (I) (was) lost saw the deceased alive on <u>9/8/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Walter E. Karfgin</u>				23B. DATE SIGNED <u>9/9/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Walter E. Karfgin</u>		23D. ADDRESS <u>4331 Harford Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-11-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Parkville,</u>		(State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4906 York Road Balto., Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8509	
P-320 71 8509 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
Potts, John David		9/7/71		645	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Union Memorial Hospital Balto 21218 Md.			Md. 2714		
5. SEX M			6. RACE W.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH		
			01-09-99 72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
MFG AGENT -			Va.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John D. Potts			Nell S. Shields		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, if unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
YES WWT			216-32-5881		
17. INFORMANT			ADDRESS		
Wife: Cecil T. Potts			Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			?		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			DUE TO, OR AS A CONSEQUENCE OF:		
			leukemic change of chron. aneurism		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)			AscVD, CHF.		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
2			yes		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
			yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
			21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR					
22. I certify that (I) (this hospital) attended the deceased from 9/1/71 to 9/7/71 that (I) (we) last saw the deceased alive on 9/5/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Karl C. Fazekas MD			9/7/71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			U. M. H.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Rem. Burial		9-10-71		Hollywood Cemetery	
24D. LOCATION (City, town, or county)		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county)	
Richmond, Va.		Hollywood Cemetery		Richmond, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 10 1971		Robert E. Jenkins, Jr.		H. W. Jenkins & Sons Co.	
				4905 York Road Balto., Md. 21212	



REG. NO.

VS 151-REV. 7/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-252 71 8511		BALTIMORE CITY HEALTH DEPARTMENT		71 8511	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HENRY COUSINS		Sept. 8 1971 6:32 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Provident Hospt. Complex 2600 Liberty Heights Avenue Baltimore, Maryland 21215		Maryland 1513			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		B.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
unemployed				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Cousins		Ida Jane Urago		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
unknown		911-18-4774		Mrs. Elizabeth Cousins	
18. 267-71		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CEREBROVASCULAR Accident		19 DAYS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) MALNUTRITION			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		URINARY TRACT INFECTION	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 26 1971 to September 8 1971 that (I) (we) last saw the deceased alive on September 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Rhodora C. Lumanon, M.D.		September 8, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9-11-71		Arbutus Memory	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 10 1971		Robert E. Taylor, M.D.		Dye H. F. H. 1701-Kauvers	

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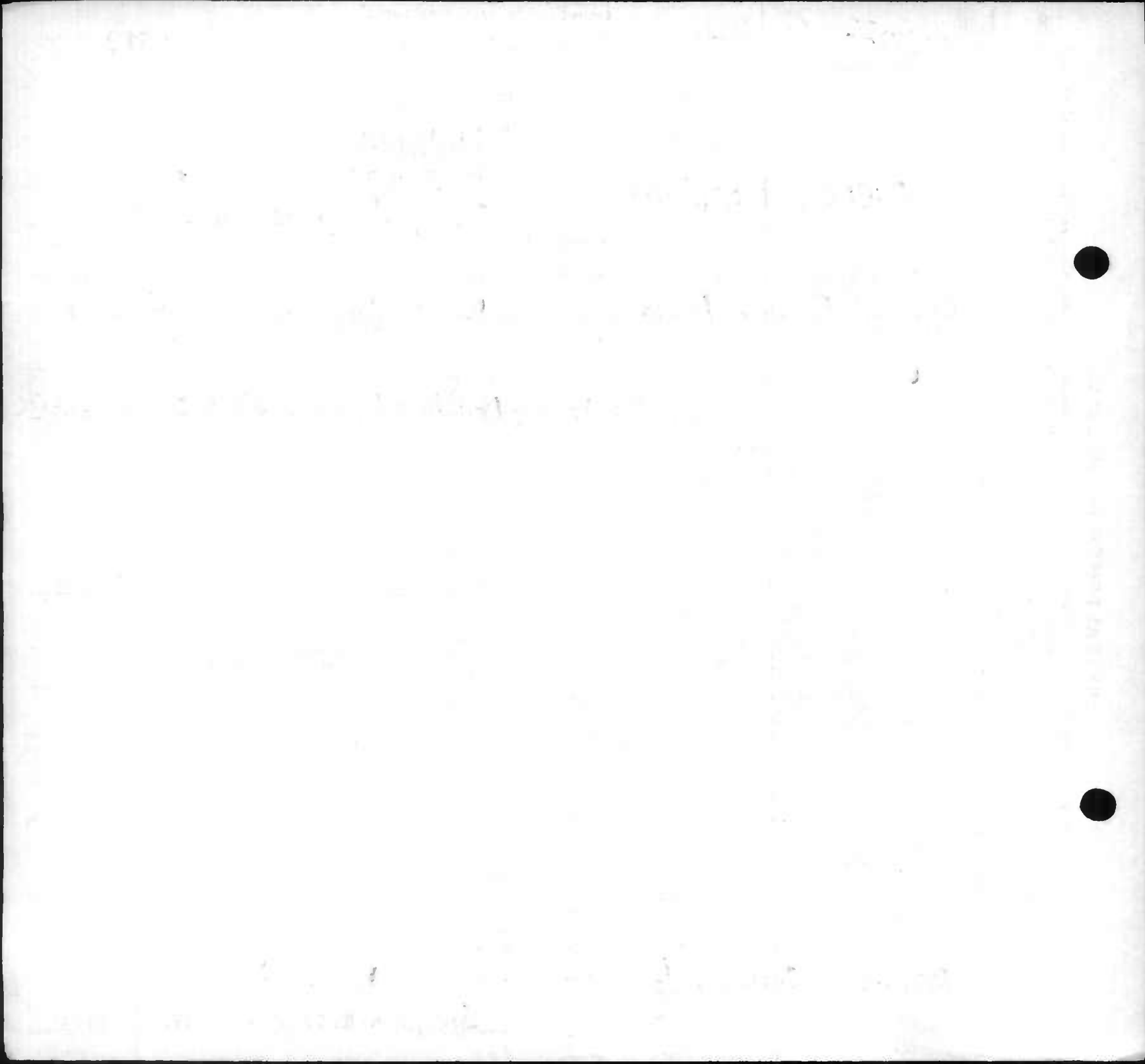
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 71 8512				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8512	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DAVID</u>				2. DATE AND HOUR OF DEATH <u>8/8/71</u> <u>9:56</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1547</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2739 Gwynns Falls Parkway</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/25</u>		9. AGE (In years last birthday) <u>46</u>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher Building</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>BOB WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE WILLIAMS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>238-44-7259</u>		17. INFORMANT <u>Mr. Robert Williams 631 M St NE Wash D.C.</u>	
18. <u>582 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>UREMIC PNEUMONITIS</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>	
				(B) <u>HASCVD & CVA</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>CHRONIC RENAL FAILURE (HYPERTENSIVE)</u>		<u>4 MOS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>D NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> 19 <u>71</u> to <u>8/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>8/8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thomas J. Brannan</u>				23B. DATE SIGNED <u>8/9/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DECEASED</u>	
23D. ADDRESS				23E. NAME of CEMETERY or CREMATORY <u>Wide Oak Cem</u>		23F. LOCATION (City, town, or county) (State) <u>Newton Grove N.C.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 12, 1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Wide Oak Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Newton Grove N.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Joseph H. Russ</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Russ</u>		25D. ADDRESS <u>2222 W. North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8513	
BIRTH NO. S-530 71 8513				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) AGNES M. SMITH			2. DATE AND HOUR OF DEATH August 25, 1971 4:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1243 Meridene Drive			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2738		
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-10-99			9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Griffin			14. MOTHER'S MAIDEN NAME Elizabeth Breneis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-12-6610		17. INFORMANT ADDRESS Mrs. Betty Zoll Same as above.
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE Massive Pulmonary Embolism, DUE TO, OR AS A CONSEQUENCE OF: Bilateral</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from Aug. 12 19 71 to August 25 19 71 that (X) (we) last saw the deceased alive on August 25 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED 8-26-71	
23C. PHYSICIAN'S NAME (Type) S.C.H. Lee, M.D.				23D. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-30-71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Baltimore, Md.	

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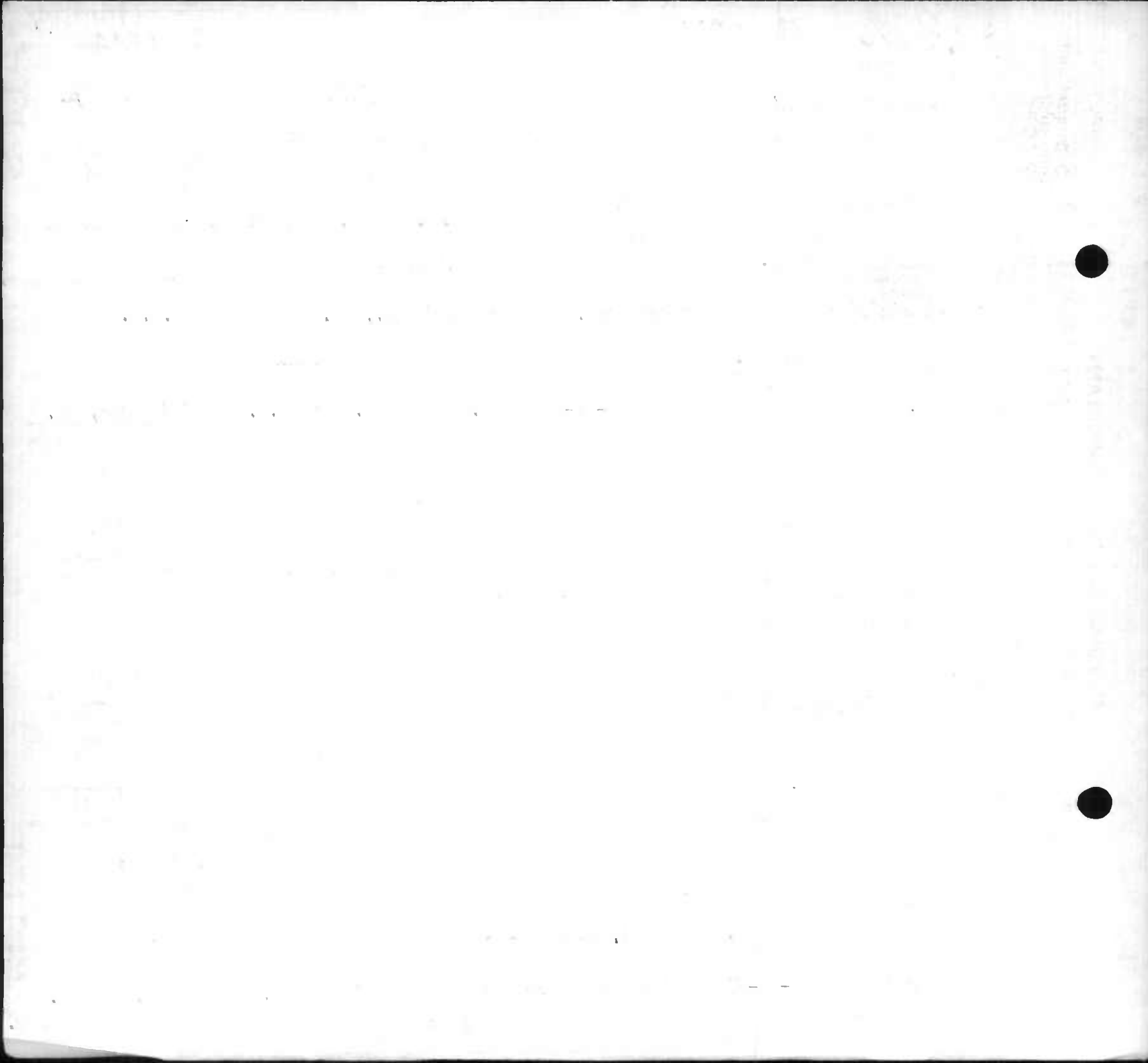
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8514	
A-140 71 8514		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) ABEL, John III			2. DATE AND HOUR OF DEATH 9/7/71 9:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Cecil C. CITY OR TOWN Rising Sun D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER R.D. #1 N. Walnut Street 21911		
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/02/17	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist		10B. KIND OF BUSINESS OR INDUSTRY Aberdeen Prov. Grounds Cecil Co., Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Abel Jr.			14. MOTHER'S MAIDEN NAME Minnie Bouchelle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 176-12-4724		17. INFORMANT Mrs. LaVerne B. Abel R.D. #2 Rising Sun, Md.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral aneurysm + edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Embolic CVA (B) DUE TO, OR AS A CONSEQUENCE OF: Double coronary (C) Myocardial Infarction 5/6 artery bypass + resection of artery APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hr. 7 days 5 mos					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9-7-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>8-27</u> 19 <u>71</u> to <u>9-7</u> 19 <u>71</u> that (I) <u>we</u> lost saw the deceased alive on <u>9-7</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE John A. Nesbitt, III			23B. DATE SIGNED 9-7-71		
23C. PHYSICIAN'S NAME (Type) John A. Nesbitt, III M.D.			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9-10-71		24C. NAME OF CEMETERY or CREMATORY Silverbrook Crematory	
24D. LOCATION (City, town, or county) (State) Wilmington, New Castle Del.		25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971			
25B. NAME OF REGISTRAR James E. ...		25C. FUNERAL DIRECTOR Pippin Funeral Home			



FUNERAL DIRECTOR: IMPORTANT

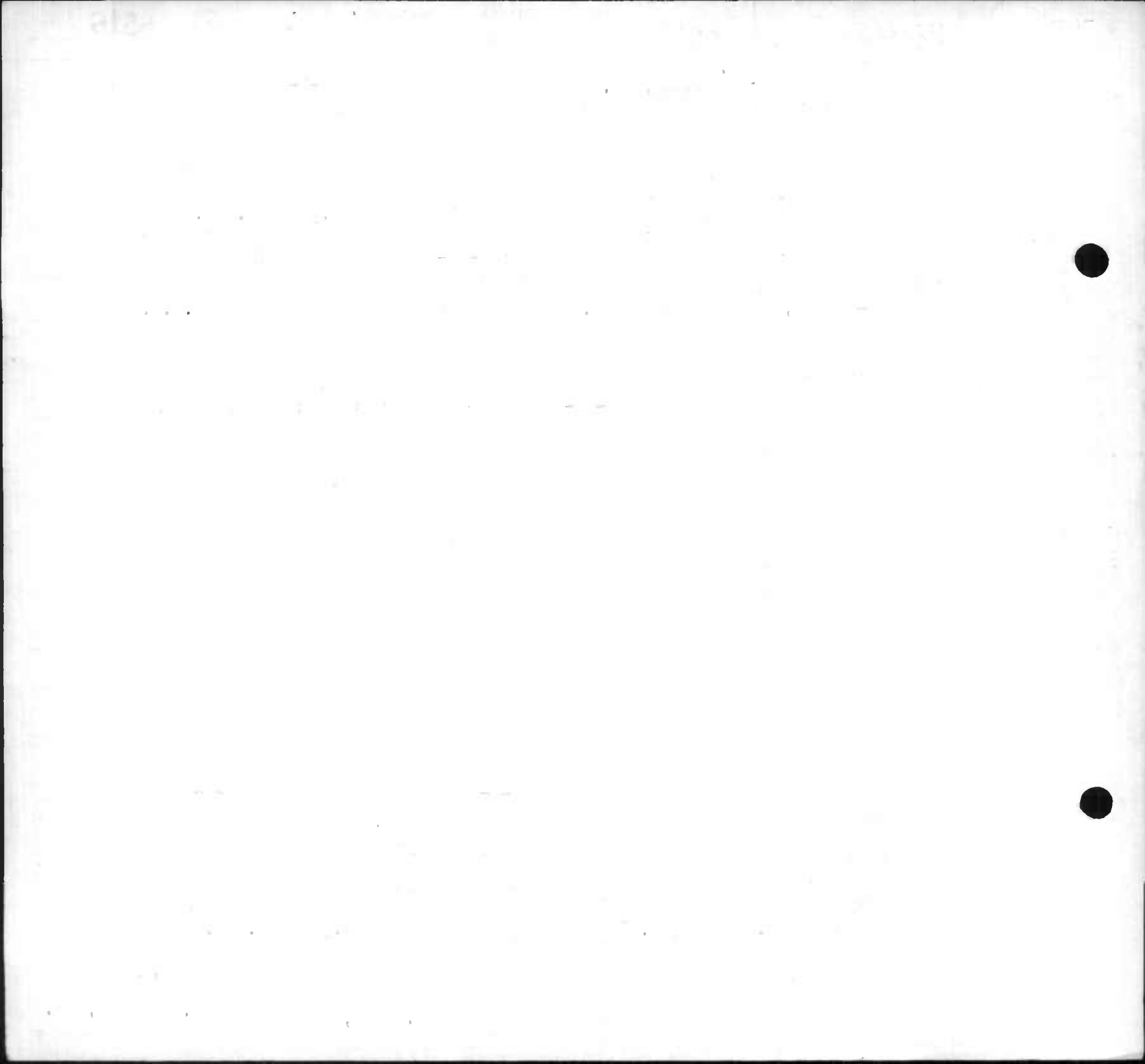
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8515</u>	
BIRTH NO. <u>M-60071 8515</u>					
1. NAME OF DECEASED (Type or Print) <u>Moore Ruth B</u>		2. DATE AND HOUR OF DEATH <u>9/5/71 1:53 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>MONTGOMERY</u> C. CITY OR TOWN <u>CHEVY CHASE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5480 WISCONSIN AVE N.W. - APT 1004</u>			
5. SEX <u>F</u>	6. RACE <u>Car</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-30-02</u>		9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
13. FATHER'S NAME <u>HERMAN R. BYRON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-70-8334</u>		17. INFORMANT <u>Mrs. William B. Crouch, 11511 Farmland Dr. Rockville, Md. 20852</u>	
18. <u>713.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Emboli</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Postop - Total Hip Replacement</u> <u>Obesity</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Emboli</u> (B) <u>Postop - Total Hip Replacement</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Obesity</u> (C) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 d.</u> <u>x years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/25/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>asthma</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/19/71</u> 19 <u>71</u> to <u>9/5/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/5/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K. O'Neill</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>KAREN O'NEILL, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/8/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>JOSEPH CAWLER'S SONS INC.</u>		25D. ADDRESS <u>5130 WISC. AVE. N.W. WASH., D.C. 20016</u>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>W-425</i> <i>71</i> <i>8516</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>71</i> <i>8516</i>	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>M.</i> <i>Herbert Wilson, Sr.</i>				2. DATE AND HOUR OF DEATH <i>9-6-71</i> <i>11:35 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2634</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>5302 Wright Ave., Balto. Md. 21205</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-98</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Driver, Quality Coffee Co.</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lee Wilson</i>				14. MOTHER'S MAIDEN NAME <i>Kate?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-20-3204</i>		17. INFORMANT <i>BCH Records: Baltimore, Maryland 21224</i>	
18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Cardiopulmonary arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Bronchitis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i> <i>10 years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-6-71</i> 19 <i>9-6-71</i> 19 that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert H. Creech, M.D.</i> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-6-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert H. Creech, M.D.</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave., Balto. Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/9/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 10 1971</i>		25B. NAME OF REGISTRAR <i>Robert H. Creech, M.D.</i>		25C. FUNERAL DIRECTOR <i>John D. Puda</i>		ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>	



I am a not a med. exam. case. Dr. Spitz
FUNERAL DIRECTOR: IMPORTANT

1
S-35171 8517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8517

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) Beulah M. Stump

2. DATE AND HOUR OF DEATH
Sept. 7, 1971 5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 2634

5. SEX Female 6. RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH March 10, 1918 9. AGE (In years last birthday) 53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY U. S. A.

13. FATHER'S NAME Milroy Hall 14. MOTHER'S MAIDEN NAME Fay Bonner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None

17. INFORMANT (Husband) 921 Alricks Way Mr. Johnson L. Stump, Baltimore, Maryland ADDRESS

18. 250.9 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct

(B) DUE TO, OR AS A CONSEQUENCE OF: HT CRP

(C) Diabetes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

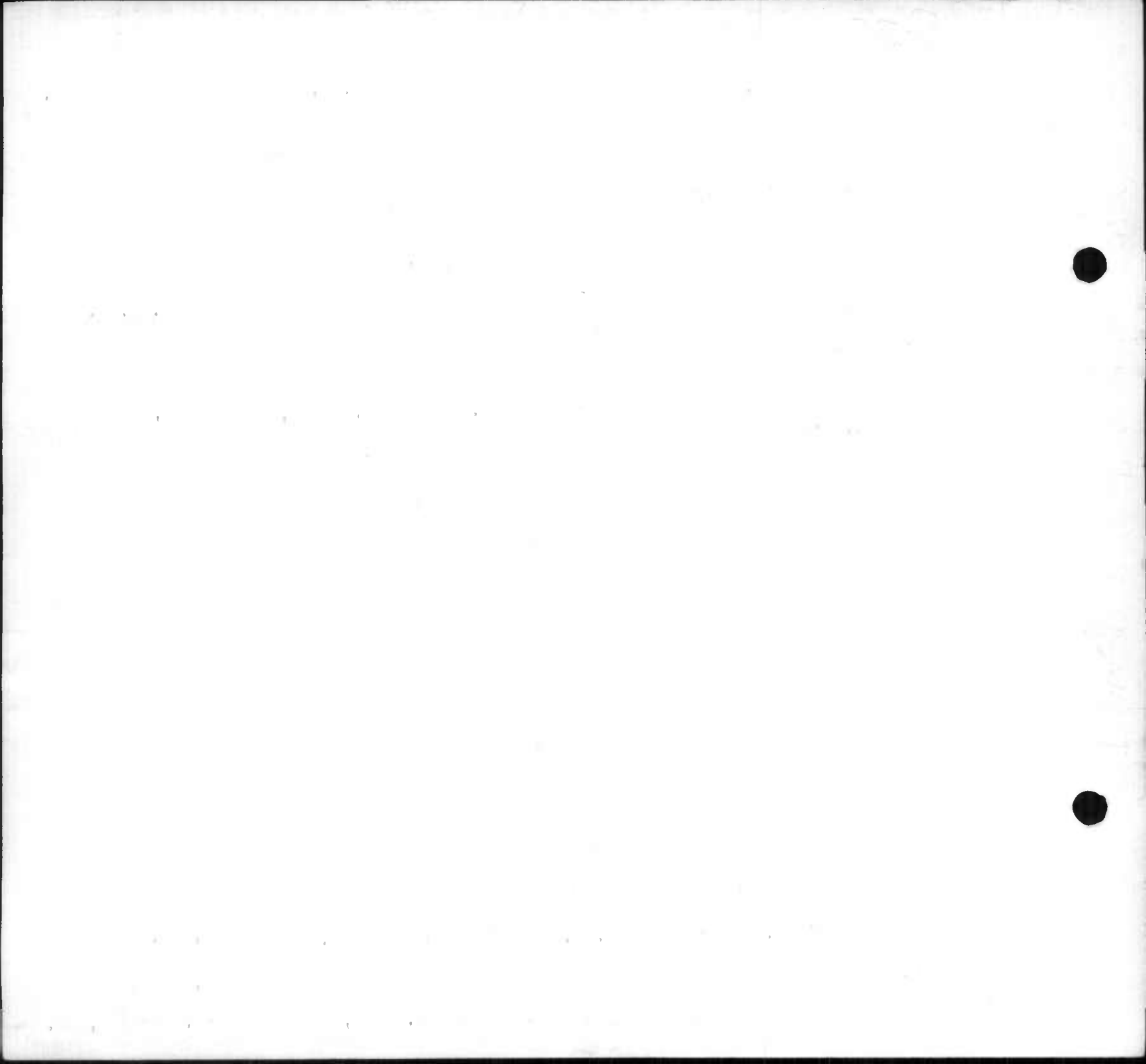
22. I certify that (I) (this hospital) attended the deceased from 5-14-1971 to 9-7-1971 that (I) (we) last saw the deceased alive on 5-14-1971 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE Marvin J. Rombro M. D. 23B. DATE SIGNED 9/8/71

23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS 805 Fuselage Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/10/71 24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens 24D. LOCATION (City, town, or county) (State) Bel Air, Maryland

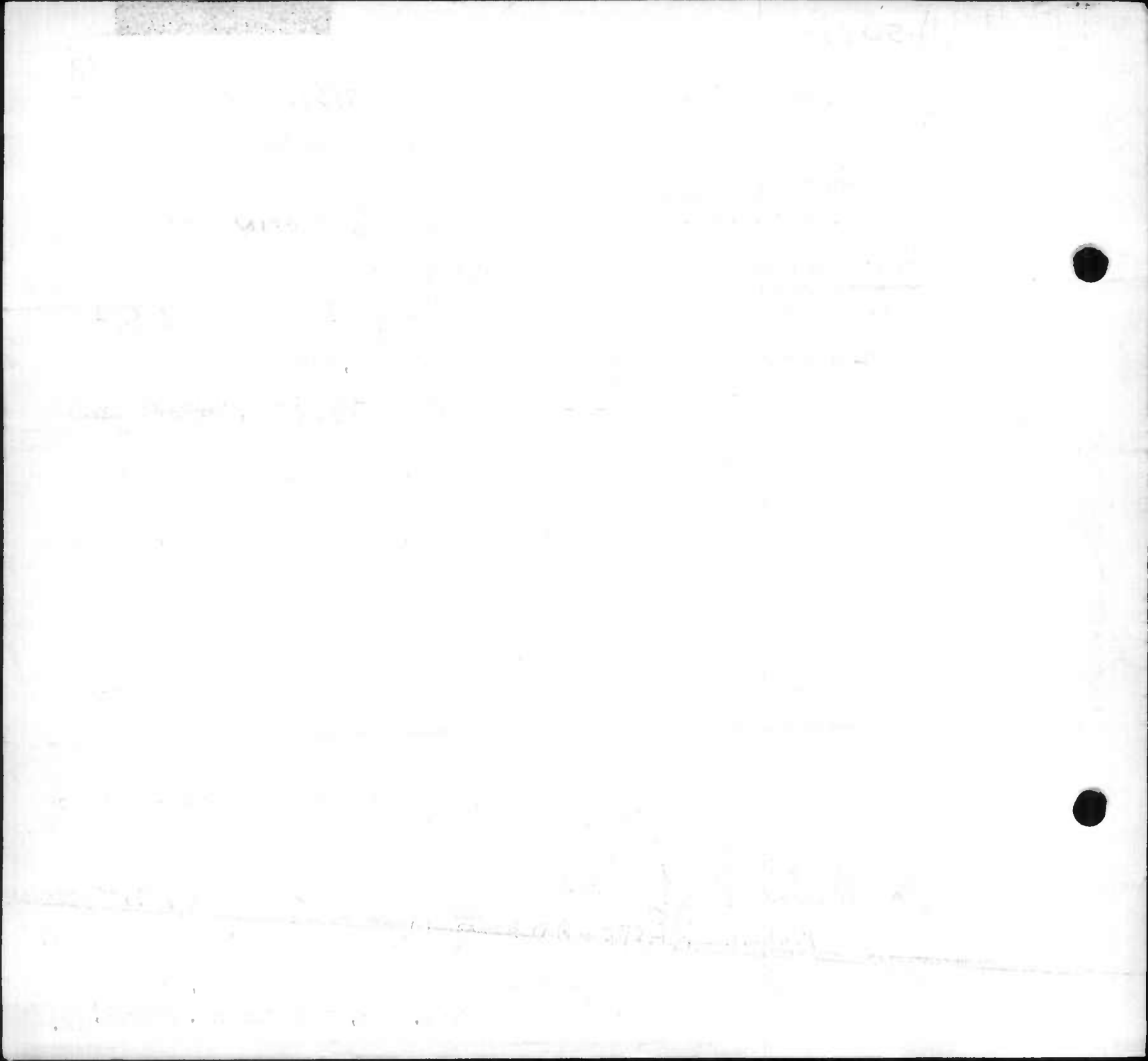
25A. DATE REC'D BY HEALTH DEPT. SEP 10 1971 25B. NAME OF REGISTRAR John J. Duda 25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		71 8518 P	
DEAN, Mary Anna		9/6/71 - 8:45			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Hampden Baltimore 5300			
31 Baltimore City Hosp. 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		2908 DUNBRIDGE Court	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov 25, 1899	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
Van CHANEY		Bolton		U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-10-5312D		BCH RECORDS - 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 Hrs	
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		APR. 10 YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from SEPT 6 - 7:30 PM 19 71 to SEPT 6 - 8:45 19 71 that (1) (we) last saw the deceased alive on SEPT 6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Michael R. Ruff M.D.		9/6/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Michael R. Ruff M.D.		Baltimore City Hosp. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/10/71		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 10 1971		John J. Duda		7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8519	
CERTIFICATE OF DEATH					
M-435 BIRTH NO.		71 8519			
1. NAME OF DECEASED (Type or Print) MOULDEN, JOHN JOSEPH			2. DATE AND HOUR OF DEATH SEPTEMBER 10, 1971 5:30A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 4-0			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY 5300		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-16-10 10-10-70			9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN R. MOULDEN			14. MOTHER'S MAIDEN NAME (BROCHES) ALICE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216 10 9097		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Standstill</i> (B) <i>Acute Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from AUGUST 31, 1971 to SEPTEMBER 10, 1971 that (X) (we) last saw the deceased alive on SEPTEMBER 10, 1971 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE <i>Tarigh Mahmood</i>			23B. DATE SIGNED 09 10 71		23C. PHYSICIAN'S NAME (Type) TARIGH MAHMOOD, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-13-1971		24C. NAME OF CEMETERY or CREMATORY Loudon Park
25A. SEP 13, 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228

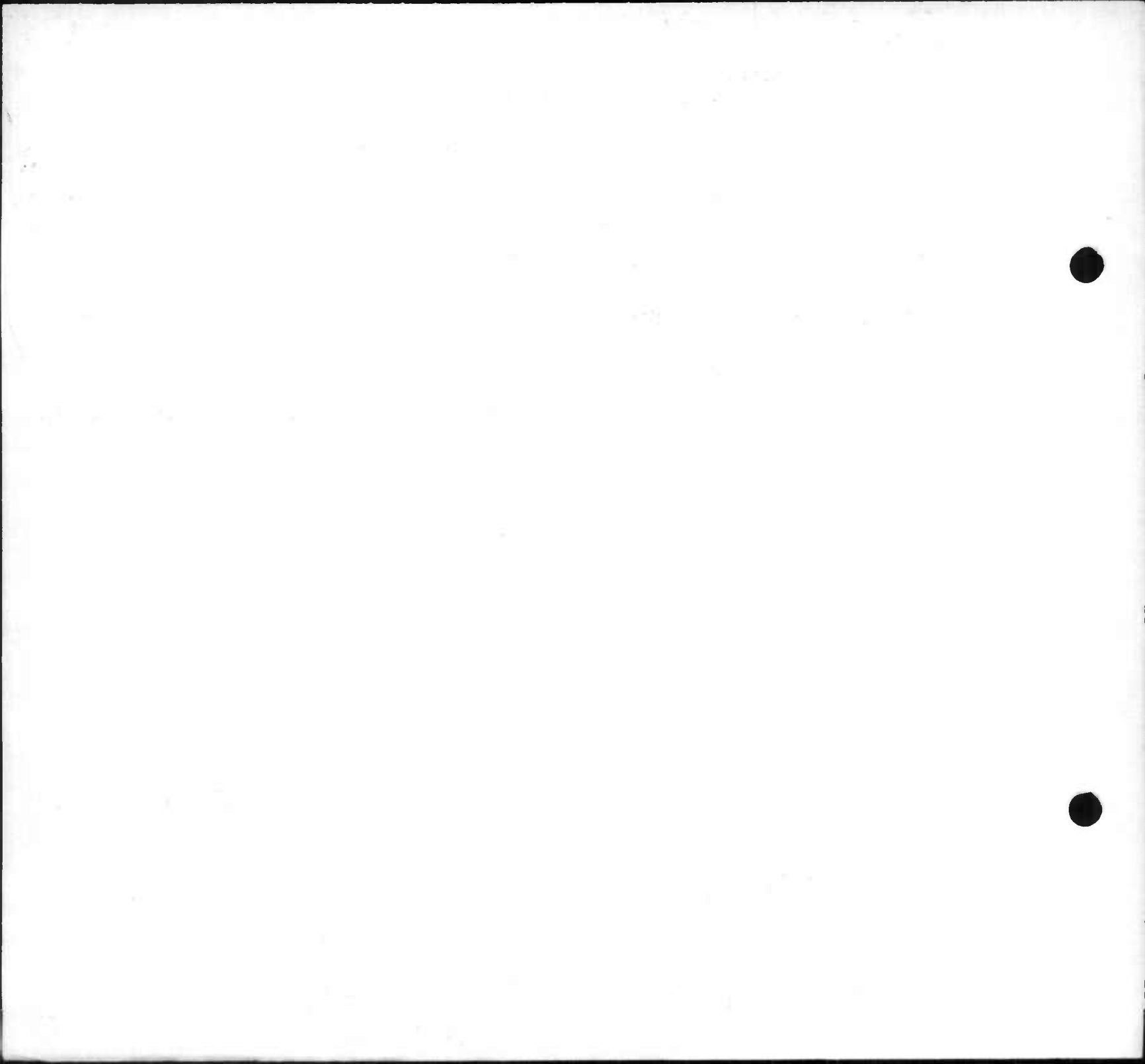
1

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 8520	
1. NAME OF DECEASED (Type or Print) GEORGE J. NOVAK				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 504 N. Glover Street				3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1971 4:50 A.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-1-1910				10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME NOVAK		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 702	
15. MOTHER'S MAIDEN NAME MARY BAURENSCHAUB				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 213-09-6691				18. INFORMANT ADDRESS Mrs. Josephine H. Novak - 504 N. Glover St.			
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 9-13-71				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED September 9, 1971							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE Cem.		24D. LOCATION (City, town, or county) (State) BALTO., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 18 1971		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR Joseph H. Jones		ADDRESS 2334 Jefferson St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-656 71 8521		BALTIMORE CITY HEALTH DEPARTMENT		71 8521	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (ANNA) (Type or Print) ANNIE E. SCHREINER			2. DATE AND HOUR OF DEATH 9-10-71 8:10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Mt. Sinai Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 603		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt. Sinai Nursing Home			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3-14-94		9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Miller		
14. MOTHER'S MAIDEN NAME Theresa Schlecht			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. Carl L. Schreiner - 3207 Hamilton Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Cerebral Vascular Acc. DUE TO, OR AS A CONSEQUENCE OF: Rt. Hemiplegia (B) Aphasia DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/3/71 19 71 to 9/10 19 71 that (I) (we) last saw the deceased alive on 9/10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. S. Harkins			23B. DATE SIGNED 9/10/71		23C. PHYSICIAN'S NAME (Type) R. S. Harkins
23D. ADDRESS 6000 PARK HTS AV			23E. FUNERAL DIRECTOR Garth Miller - 2334 Jefferson St.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE Cem.	
24D. LOCATION BALTO. MD.		24E. ADDRESS 2334 Jefferson St.			
25A. DATE OF DEATH SEP 13 1971					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8522</u>
BIRTH NO. <u>P-620 71 8522</u>				
1. NAME OF DECEASED (Type or Print) <u>JOSEPH H. PRICE</u>		2. DATE AND HOUR OF DEATH <u>9/9/71</u> <u>2:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>702</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>N. MILTON AVE. 634</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/90</u>	9. AGE (In years last birthday) <u>81</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEVATOR OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>INS. BLDG.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH PRICE</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN MARY ASHLEY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Ann. Ann. Price - 634 N. MILTON AVE.</u>		
18. <u>712.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DUODENAL ULCER</u>				
19A. DATE OF OPERATION <u>9/7/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>HERNIOPLASTY</u>		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/23/71</u> 19 <u>71</u> to <u>9/9/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/9/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joe Paz</u>		23B. DATE SIGNED <u>9/9/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>JOSE PAZ</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-13-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>				
25A. DATE REC'D. BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Miller - 2334 Jefferson St.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-125 71 8523		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8523	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY HOPKINS</u>		2. DATE AND HOUR OF DEATH <u>9-10-71</u> <u>1</u> <u>1</u> <u>a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1205</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Dukeland Nursing Home</u> <u>1501 Dukeland ST</u> <u>Baltimore, Md 21216</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1718 Barclay ST</u>					
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-03</u>	9. AGE (if years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-0097</u>		17. INFORMANT ADDRESS	
18. <u>199.0 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> <u>1970</u> to <u>9/9</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>9/9</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Perceval E. Smith</u>		23B. DATE SIGNED <u>9-10-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Perceval E. Smith</u>	
23D. ADDRESS <u>4200 Edmondson</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>SEPT 13-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt AUBURN CEMT</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTI. MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>JL BROWN</u>	
				ADDRESS <u>123 W MONTGOMERY ST</u>	

214 7283

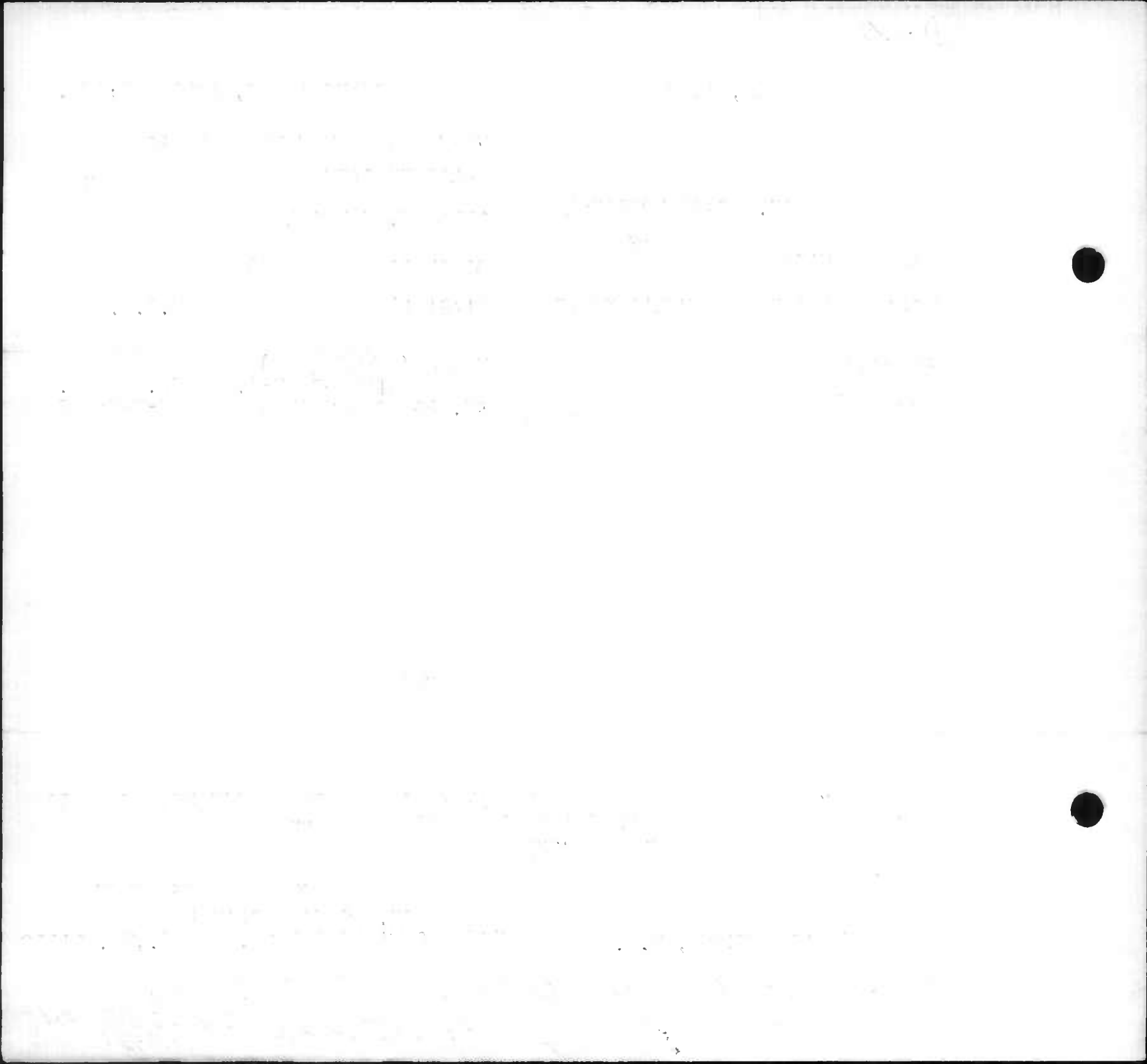
7450 11044 11045

11046

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8524	
D-40 71 8524				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DELP, CLAUDE		SEPTEMBER 5, 1971 7:15A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
40 ST. AGNES HOSPITAL			MARYLAND HOWARD 21-043 6300		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			ELLICOTT CITY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			2770 ST. JOHNS LANE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01 02 11	60	11 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MACHINE OPERATOR		PUBLICATIONS		VIRGINIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
APP DELP			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		408-24-5689		WILKENS AVES. BALTO. ADDRESS MD. ST. AGNES HOSPITAL RECORDS-CATON &	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Thrombosis Anterior Branch of Left Coronary Artery		
ANTECEDENT CAUSES			(B) Anterolateral Myocardial infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 3 19 71 to SEPTEMBER 5 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 5 19 71 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
TARIG MAHMOOD, M.D.			09 05 71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-8-71		Good Shepherd	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 13 1971		Robert E. Fisher, M.D.		Miguel Slack	
				Ellicott City, Md	



FUNERAL DIRECTOR: IMPORTANT

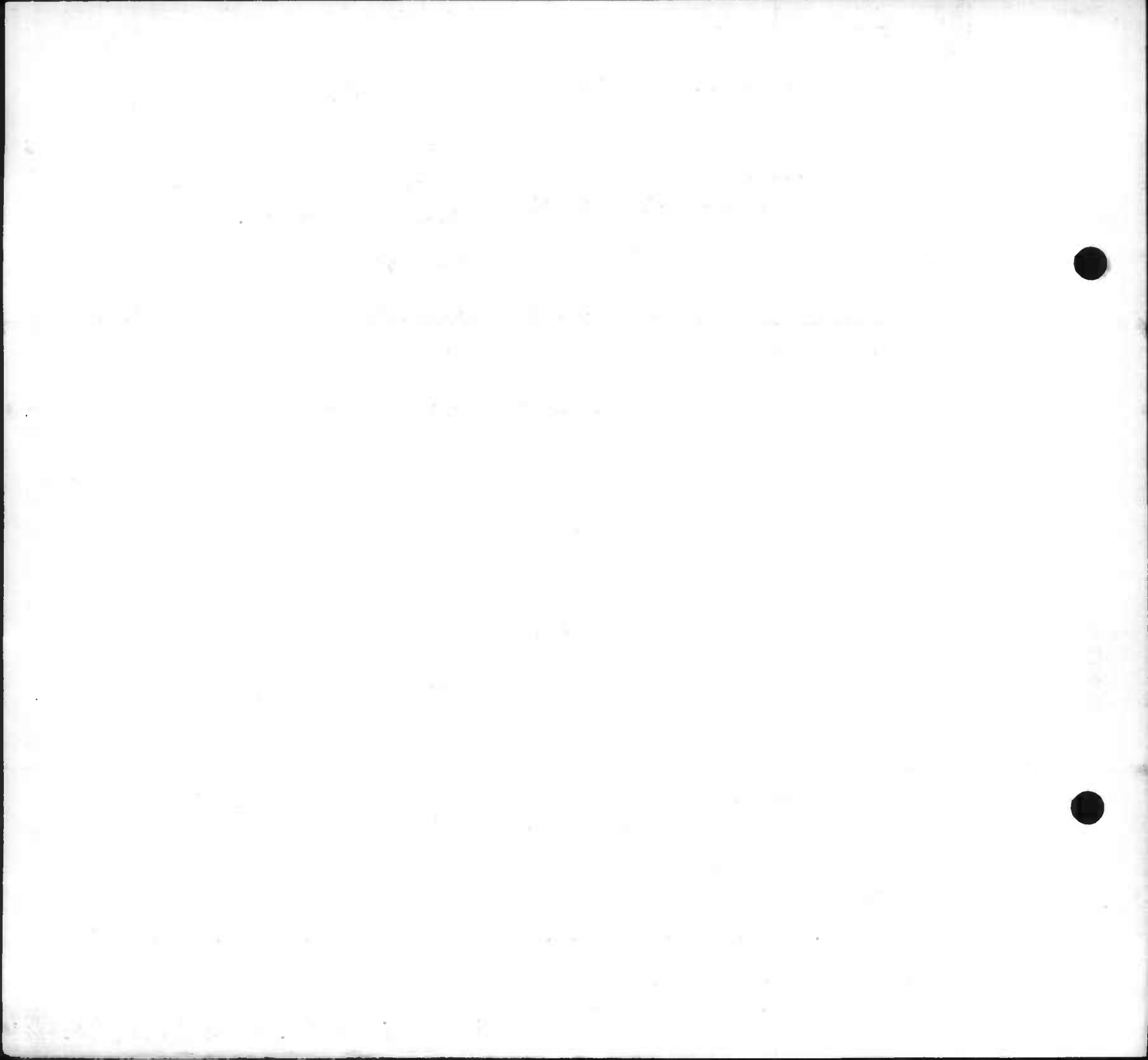
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8525</u>	
W-435 '71 8525				CERTIFICATE OF DEATH	
BIRTH NO. <u>W-435 '71 8525</u>					
1. NAME OF DECEASED (Type or Print) <u>Waldner, Philip C.</u>		2. DATE AND HOUR OF DEATH <u>9/6/71</u> <u>10¹⁰</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>Balto. Md. 21218</u>		A. STATE <u>Md.</u>		B. COUNTY <u>2745</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>Edna Rd. 6007</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-93</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Watkins Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Waldner, (P.) Charles H.</u>		14. MOTHER'S MAIDEN NAME <u>? Anne K. Zink</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-01-3939</u>		17. INFORMANT <u>Sohn: John Waldner</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>204.1 I</u> <u>Gaupren - Septicemia (cellulitis)</u> <u>Cardiovascular collapse</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>chron. lymphatic leukemia</u> <u>transition to acute phase</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD, CHF</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>?</u> <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>?</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/5</u> <u>71</u> to <u>9/6</u> <u>71</u> that (2) (we) last saw the deceased alive on <u>9/5</u> <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Fazel</u> <u>MD.</u>				23B. DATE SIGNED <u>9/6/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. FAZEKAS</u> <u>MD.</u>				23D. ADDRESS <u>U. U. H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/9/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION <u>Baltimore</u>		24E. LOCATION <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert C. Fazel</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u> <u>6009 Harford Rd. - Balto., Md. 21214</u>	

12 25 21

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

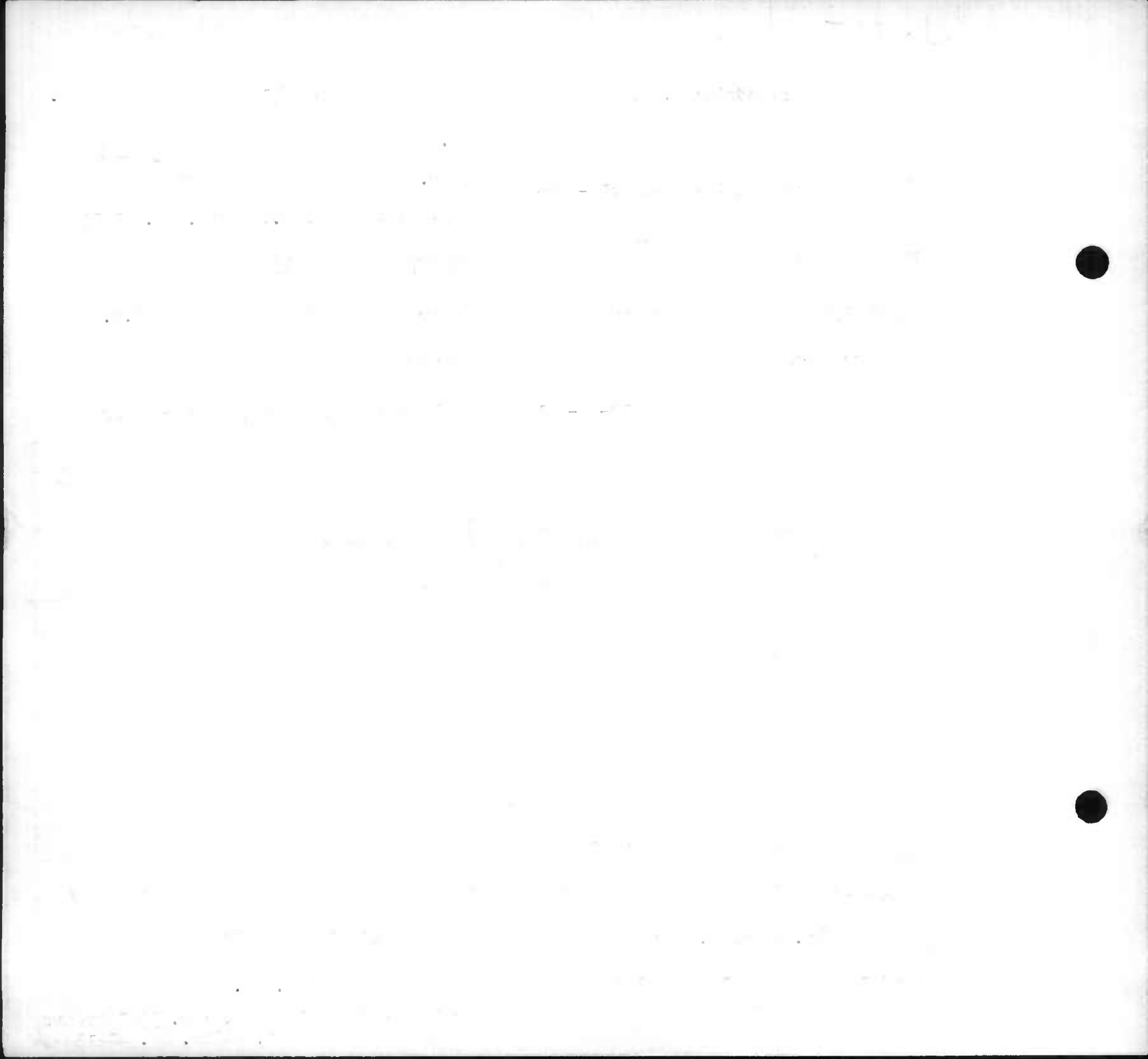
BIRTH NO.		Baltimore City Health Department		CERTIFICATE OF DEATH		REG. NO.	
7-632		71 8526				71 8526	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Edward T. Fritsche				9/7/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
D.O.A. Union Memorial Hospital				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3009 Roselawn Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/27/1913	57		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Plumber				Sinai Hospital		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Herman Fritsche				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				214-03-1850		Gertrude Fritsche - 3009 Roselawn Ave	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Coronary insufficiency 13 years			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Coronary arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Pancreatitis chronic			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>Mar. 9</u> 19 <u>55</u> to <u>Sept 7</u> 19 <u>71</u> that (I) <u>was</u> lost saw the deceased alive on <u>June 9</u> 19 <u>71</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> <u>did not</u> view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<u>R. Donald Jandorf</u>				9-8-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
R. Donald Jandorf, M.D.				7403 Harford Rd.-Balto., Md. 21234			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/11/71		Parkwood Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 13 1971		Robert C. Altenburg		Robert C. Altenburg		6009 Harford Rd. - Baltimore, Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

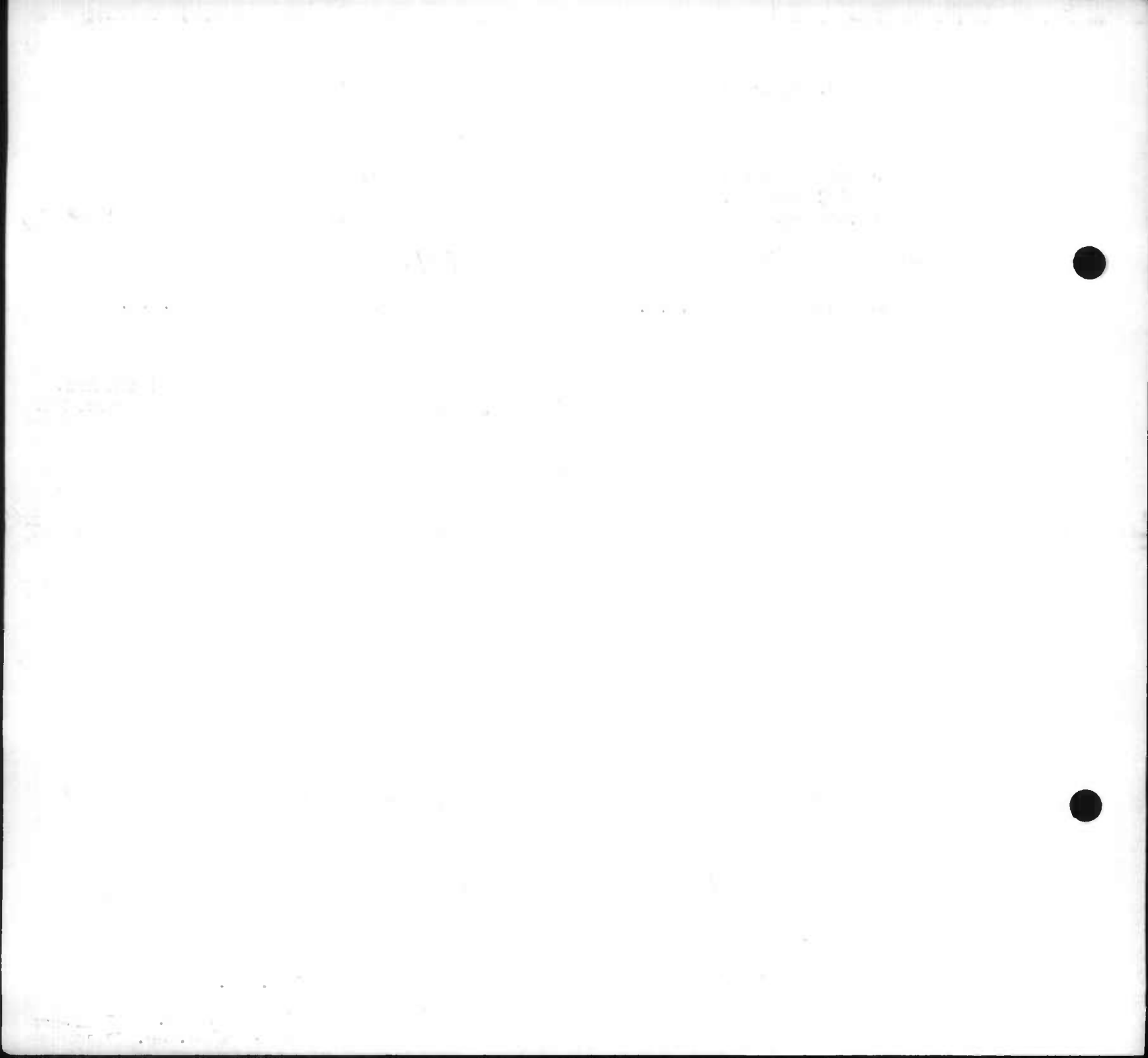
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8527	
BIRTH NO. J-525 71 8527					
1. NAME OF DECEASED (Type or Print) Katherine G. Janzen		2. DATE AND HOUR OF DEATH 9/6/71 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital - DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2643			
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3447 Clifftmont Ave., Balto. Md. 21213			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/97	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-03-6910		17. INFORMANT ADDRESS Arnold Janzen (husband) same address	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with Mitral Stenosis & Atrial (B) DUE TO, OR AS A CONSEQUENCE OF: fibrillation (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/11/64 19 to 6/15/71 19 that (I) (we) last saw the deceased alive on 6/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE James R. Karns		23B. DATE SIGNED 9/8/71			
23C. PHYSICIAN'S NAME (Type) Dr. James R. Karns		23D. ADDRESS Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9/9/71		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Janzen, M.D.		25C. FUNERAL DIRECTOR Schlunke Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

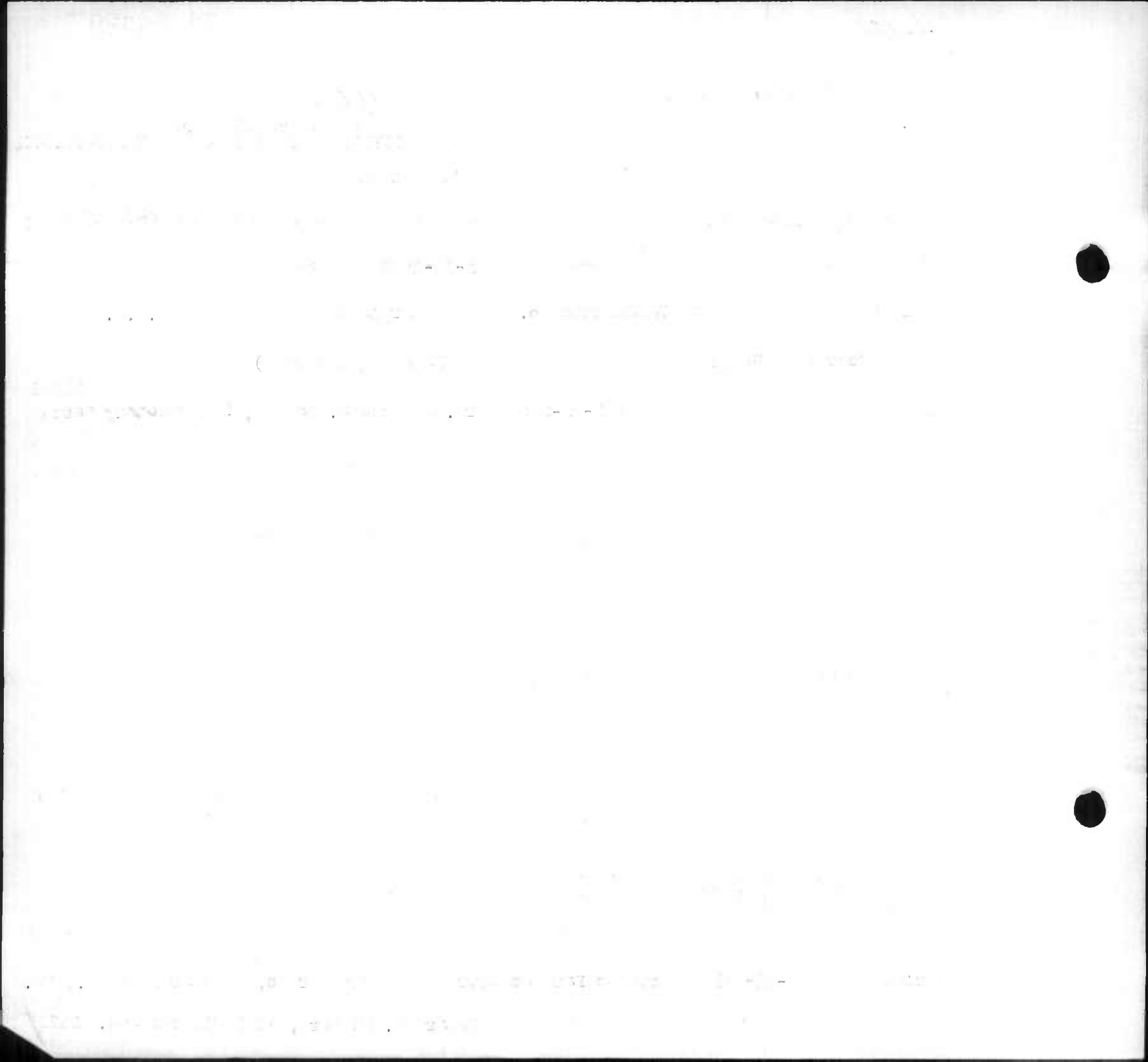
<p>G-655 71 8528</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8528</p>	
<p>1. NAME OF DECEASED (Type or Print) Mr. Albert Gorman</p>			<p>2. DATE AND HOUR OF DEATH 9/7/71 1A:M <small>AM</small></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>91 Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Maryland 21229</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Md. B. COUNTY BALTO</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 115 Hopkins Road</p>		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/90	9. AGE (in years last birthday) 81	10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler-Maker		10B. KIND OF BUSINESS OR INDUSTRY B.&O. Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Komin		14. MOTHER'S MAIDEN NAME Munak	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 705-03-6027		17. INFORMANT Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Md.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</p>			<p>(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Cachexia DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Chronic Brain Syndrome</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14 19 71 to 9/7 19 71 that (I) (we) last saw the deceased alive on 9/7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Raymond Gladue			23B. DATE SIGNED 9/7/71		
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue			23D. ADDRESS Jenkins Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 9/10/71		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 13 1971			
24F. NAME OF REGISTRAR Robert E. Gorman, M.D.		24G. FUNERAL DIRECTOR Schumacher		24H. ADDRESS Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

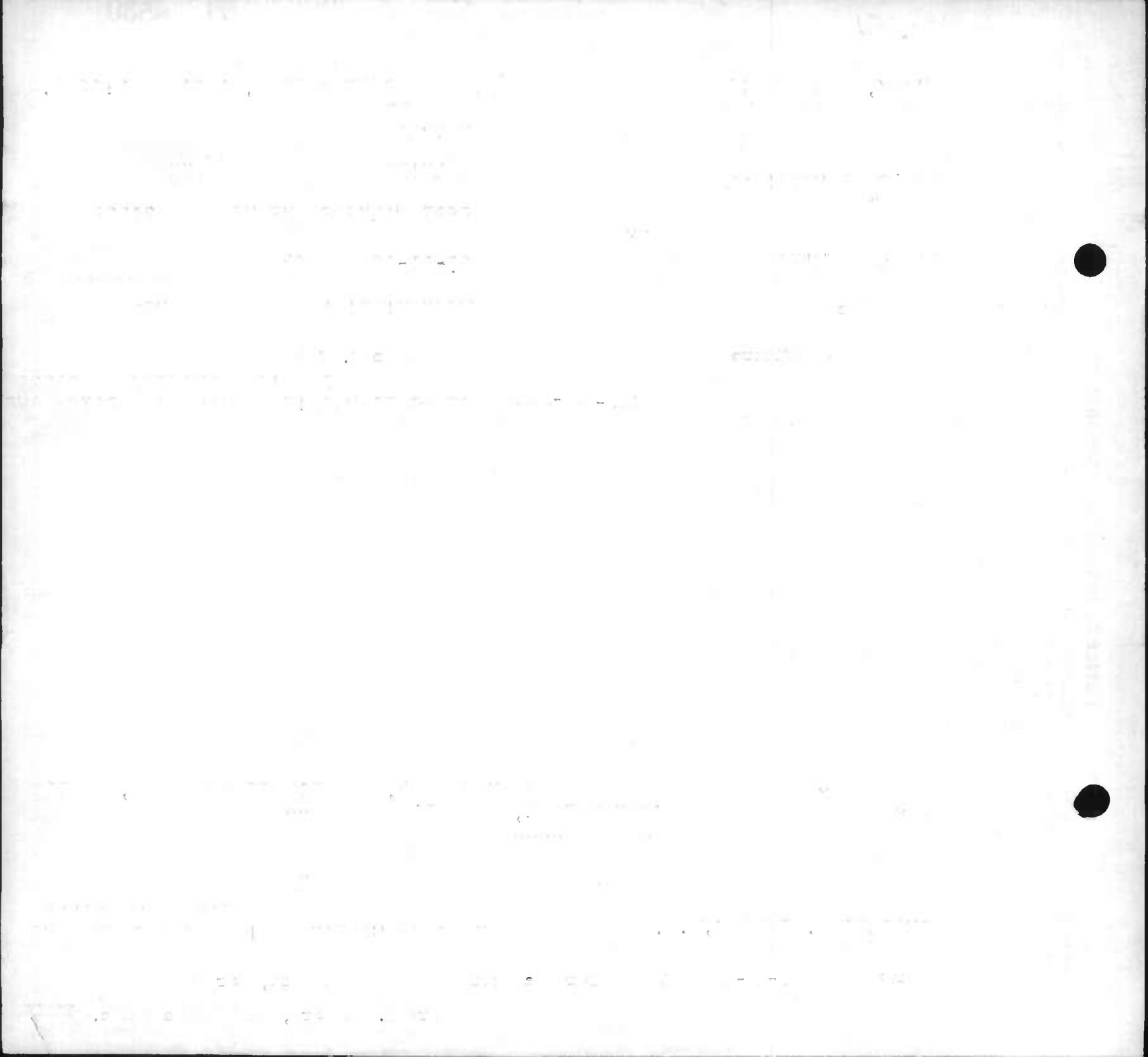
BALTIMORE CITY HEALTH DEPARTMENT				X		71 8529	
BIRTH NO. 71 8529				CERTIFICATE OF DEATH		REG. NO. 71 8529	
1. NAME OF DECEASED (Type or Print) HAUPT, August J.				2. DATE AND HOUR OF DEATH 9/7/71 10:55 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY ANNE ARUNDEL Street Address			
				C. CITY OR TOWN GlenBurnie		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 241 GLENGARY GARTH GlenBurnie			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-1902	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Haupt				14. MOTHER'S MAIDEN NAME Lena (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-3320		17. INFORMANT Mrs. Annetta M. Landon, 241 Glengary Garth			
18. 44401 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Aorto-iliac Thrombosis - (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Arteriosclerosis - (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____							
19A. DATE OF OPERATION 9/6/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED thrombosis		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/6 19 71 to 9/7 19 71 that (I) (we) last saw the deceased alive on 9/7/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jose V. Iglesias M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Jose V. Iglesias M.D.				23D. ADDRESS University of Maryland Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-11-1971		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) GlenBurnie, Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR John E. Kelly M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

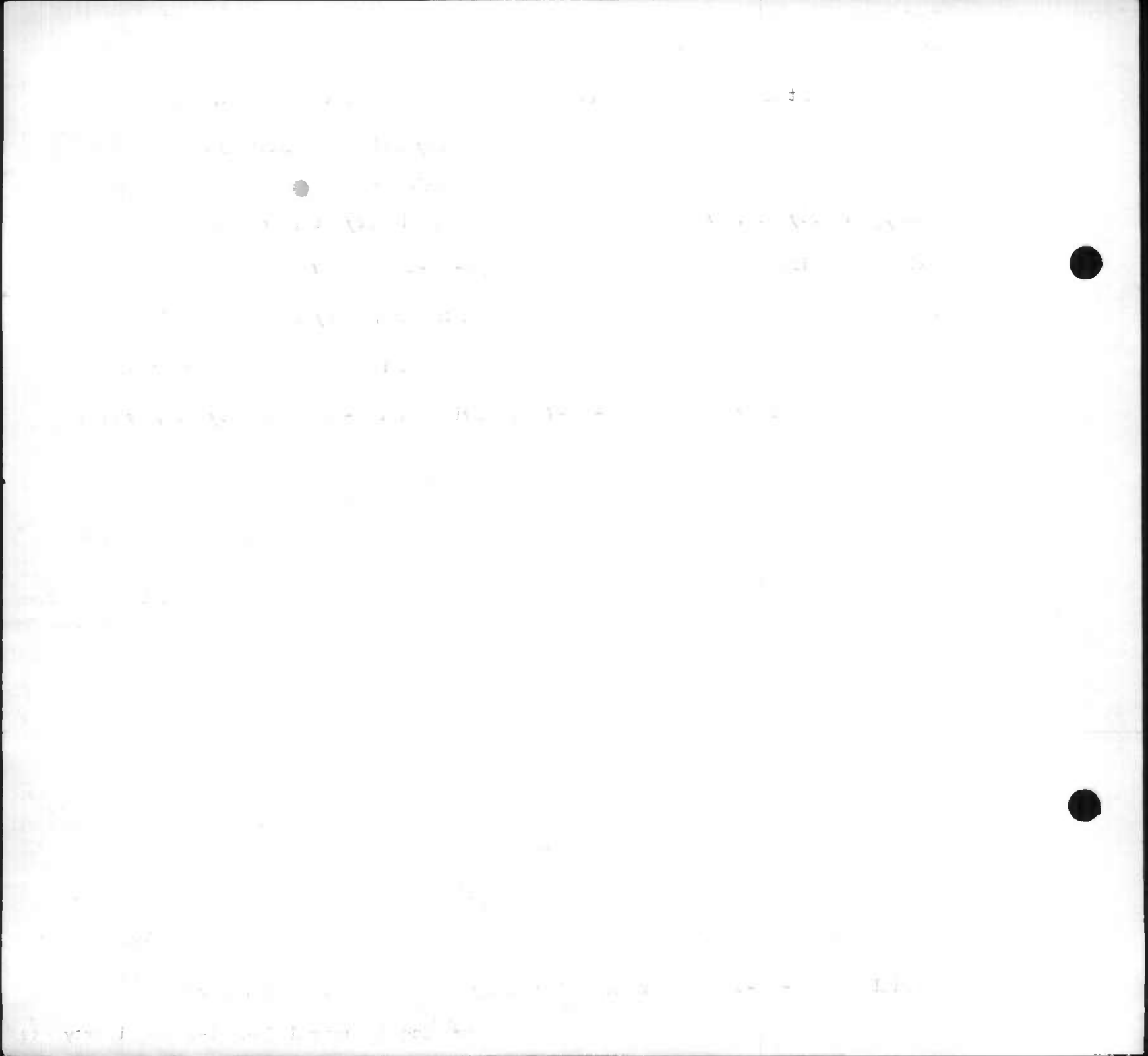
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8530
CERTIFICATE OF DEATH				REG. NO.
BIRTH NO. B-350		71 8530		
1. NAME OF DECEASED (Type or Print) BUDNY, ANNA MARIE		2. DATE AND HOUR OF DEATH SEPTEMBER 8, 1971 2:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2551		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 03-11-17 9. AGE (In years last birthday) 54
13. FATHER'S NAME Rosco Fittro		14. MOTHER'S MAIDEN NAME Madge G. Floyd		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 233-30-5665		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE
18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: 4 days		
(C) Hypertension		?		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 4, 1971 to SEPTEMBER 8, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 8, 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE C.R. Chaney DEGREE				23B. DATE SIGNED 9/8/71
23C. PHYSICIAN'S NAME (Type) CHARLES R. CHANEY, M.D. DEGREE				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		
25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229		

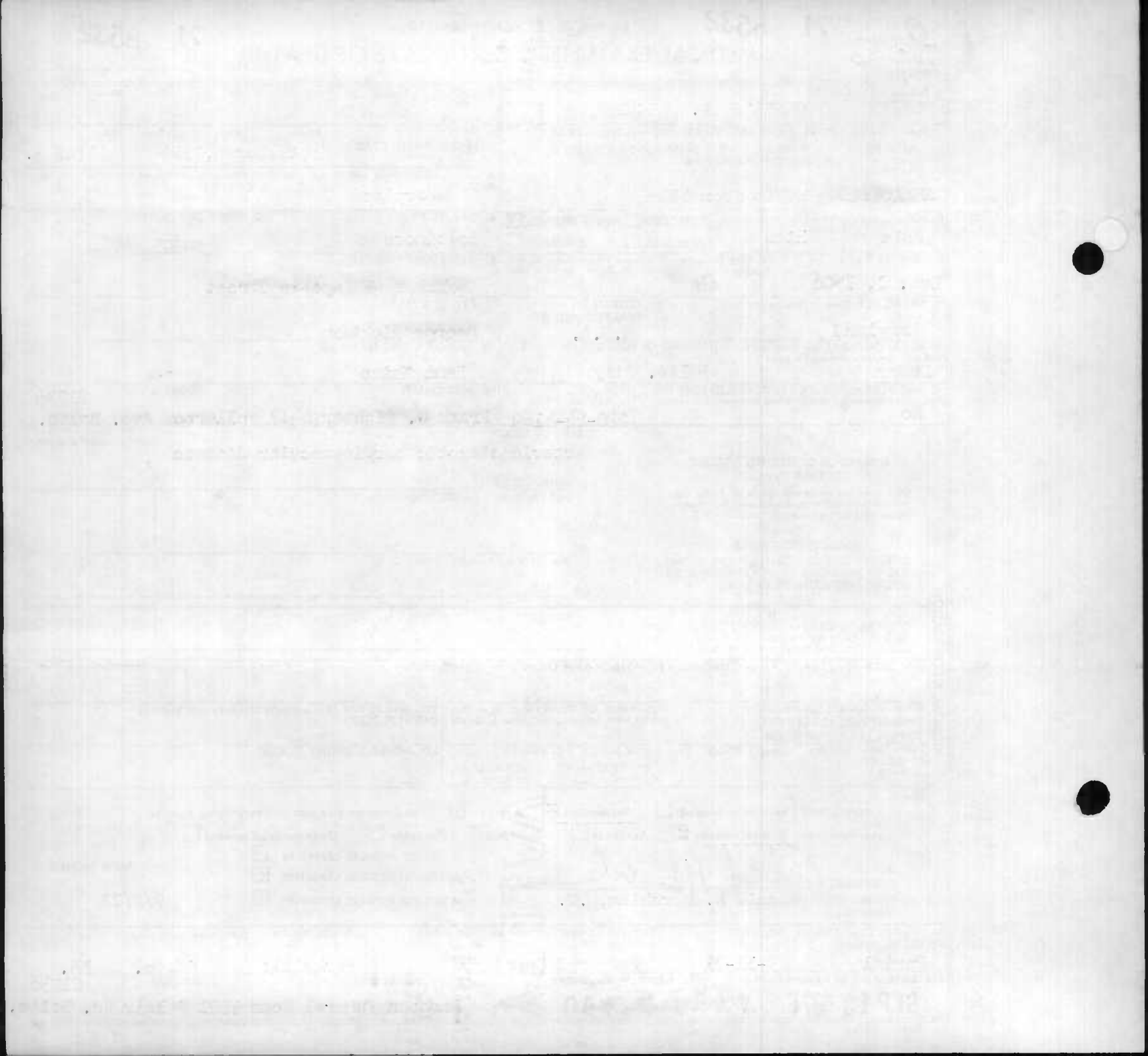


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-240 71 8531		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8531	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Walter F Eisel		September 8, 1971 8:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland Baltimore		2802	
00		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4309 Liberty Hts, Avenue		E. STREET AND NUMBER		4309 Liberty Hts, Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-18-1891	79	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk				Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Eisel		Rosalie		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW 1 Army		219-10-7617		Irving Hinton-4309 Liberty Hts, Avenue	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		5 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		5 days.	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Generalized Arterio - Sclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June - 10 19 59 to 9 / 8 19 71 that (I) (we) last saw the deceased alive on 9 / 7 / 71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Earl L. Chambers M.D.		9 / 10 / 71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Earl L. Chambers - M.D.		100 - W. Cold Spring Bathing Mf			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	9-11-71	Lorraine Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
SEP 13 1971	Reg. EX-32, M.D.	Armstrong Funeral Chapel		-4600 Liberty Hts	



VS 151-REV. 7/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-200 71 8533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8533

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **ETHEL ROBERTA PAGE**

2. DATE AND HOUR OF DEATH
9/8/71 7:24 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **PENNSYLVANIA**
B. COUNTY **V 35**

5. FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6. CITY OR TOWN
YORK

7. INSIDE CITY LIMITS?
YES ☐ NO ☒

8. STREET AND NUMBER
2317 LOUCKS RD.

9. SEX
FEMALE

10. RACE
WHITE

11. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

12. DATE OF BIRTH
06-24-16

13. AGE (In years last birthday) **55**

14. If Under 1 Yr. Months: Days: Hours: Min.

15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

16. KIND OF BUSINESS OR INDUSTRY

17. BIRTHPLACE (State or foreign country)
Fairfield, Penna.

18. CITIZEN OF WHAT COUNTRY?
U.S.A.

19. FATHER'S NAME
HOWARD CARSON

20. MOTHER'S MAIDEN NAME
LOTTIE ~~SENN~~ Stehm

21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

22. SOCIAL SECURITY NO.
174-01-3650

23. INFORMANT
Leber Funeral Home, 200 Carlisle Ave. 17404

24. ADDRESS

25. CAUSE OF DEATH

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest

27. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Unresectable Malignancy

28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 minutes

29. POSSIBLE HEMORRHAGE INTO BRAIN

30. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

31. DATE OF OPERATION
9/5/71

32. CONDITION FOR WHICH OPERATION WAS PERFORMED
Tumor

33. AUTOPSY? (Yes or No)
YES

34. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

35. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Initially medical examiner ☒ **No**

36. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

37. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

38. TIME OF INJURY (Month) (Day) (Year) (Hour)
9/5/71

39. INJURY OCCURRED
While At Work ☐ Not While At Work ☐

40. HOW DID INJURY OCCUR?

41. I certify that (I) (this hospital) attended the deceased from **9/5** 19 **71** to **9/8** 19 **71** that (I) (we) lost saw the deceased alive on **9/8** 19 **71** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

42. SIGNATURE
GREGORY B. BUCKLEY MD

43. DATE SIGNED
9/8/71

44. PHYSICIAN'S NAME (Type)
GREGORY B. BUCKLEY MD

45. ADDRESS
Johns Hopkins Hospital

46. BURIAL CREMATION REMOVAL (Specify)
Burial

47. DATE
9-11-1971

48. NAME OF CEMETERY OR CREMATORY
Lind Mem. Meth. Cemetery

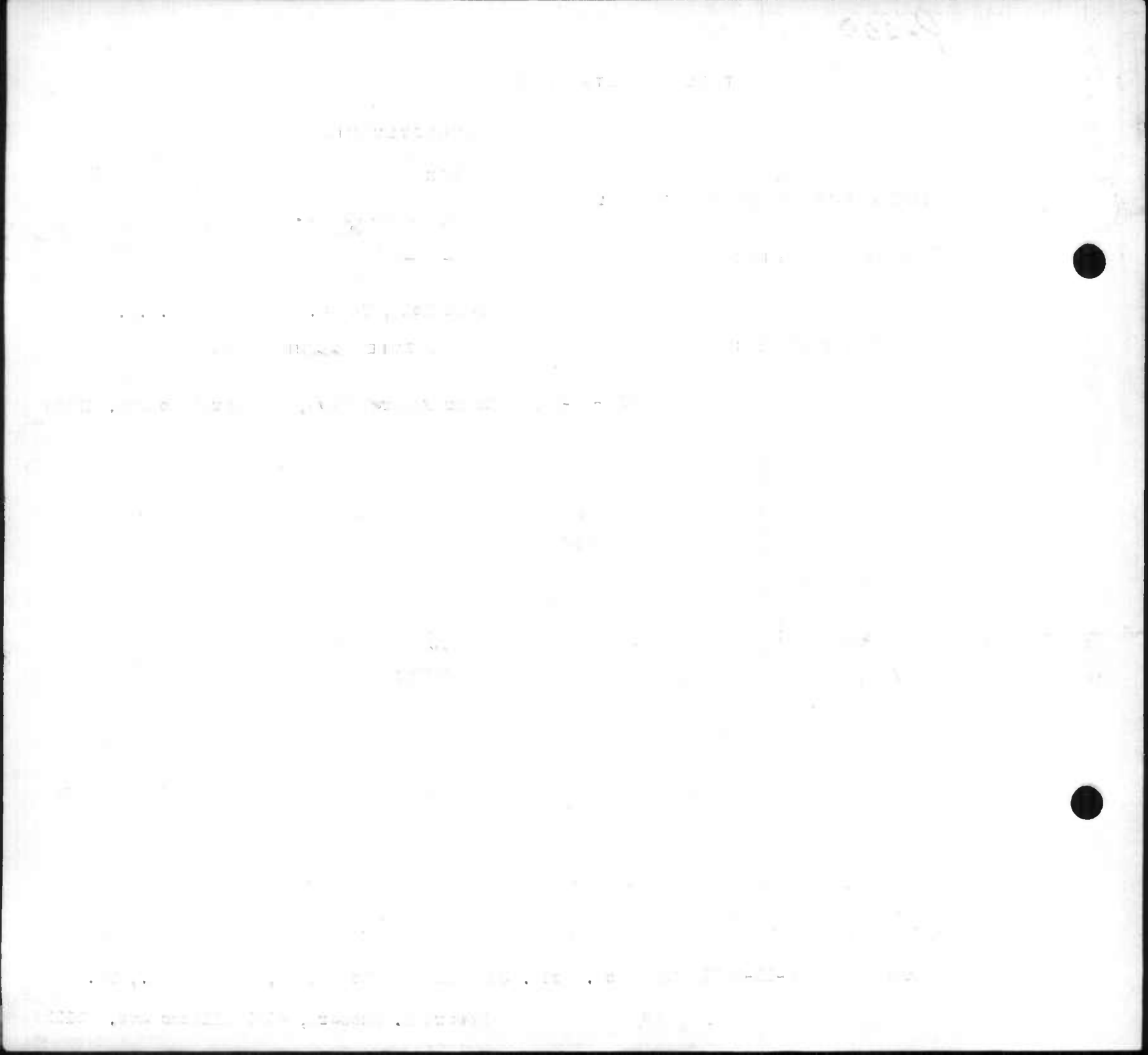
49. LOCATION (City, town, or county) (State)
Lewistown, Mifflin Co., Pa.

50. DATE REC'D BY HEALTH DEPT.
SEP 13 1971

51. NAME OF REGISTRAR
Robert E. Fisher, MD.

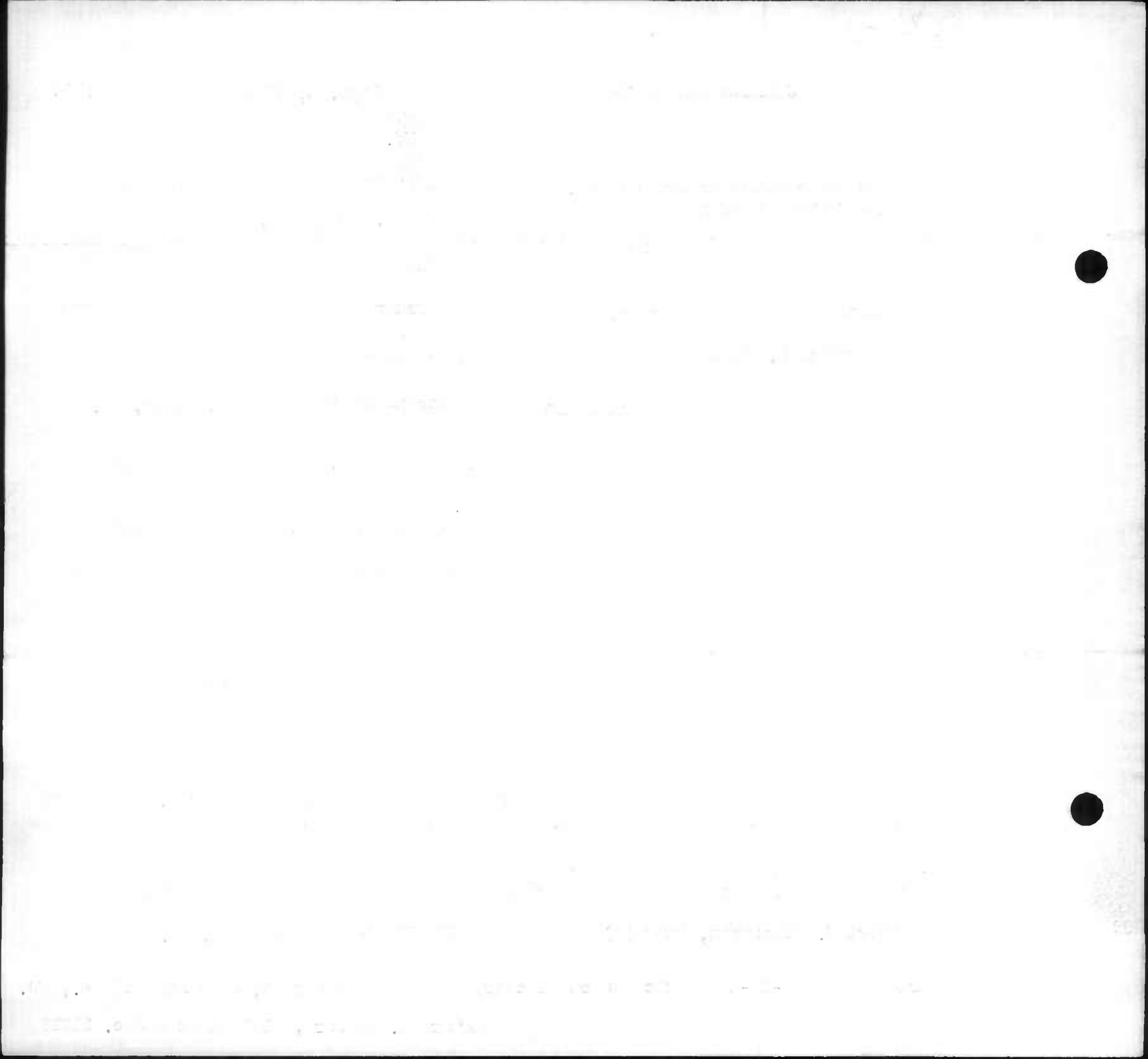
52. FUNERAL DIRECTOR
Howard H. Hubbard

53. ADDRESS
4107 Wilkens Ave. 21229



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

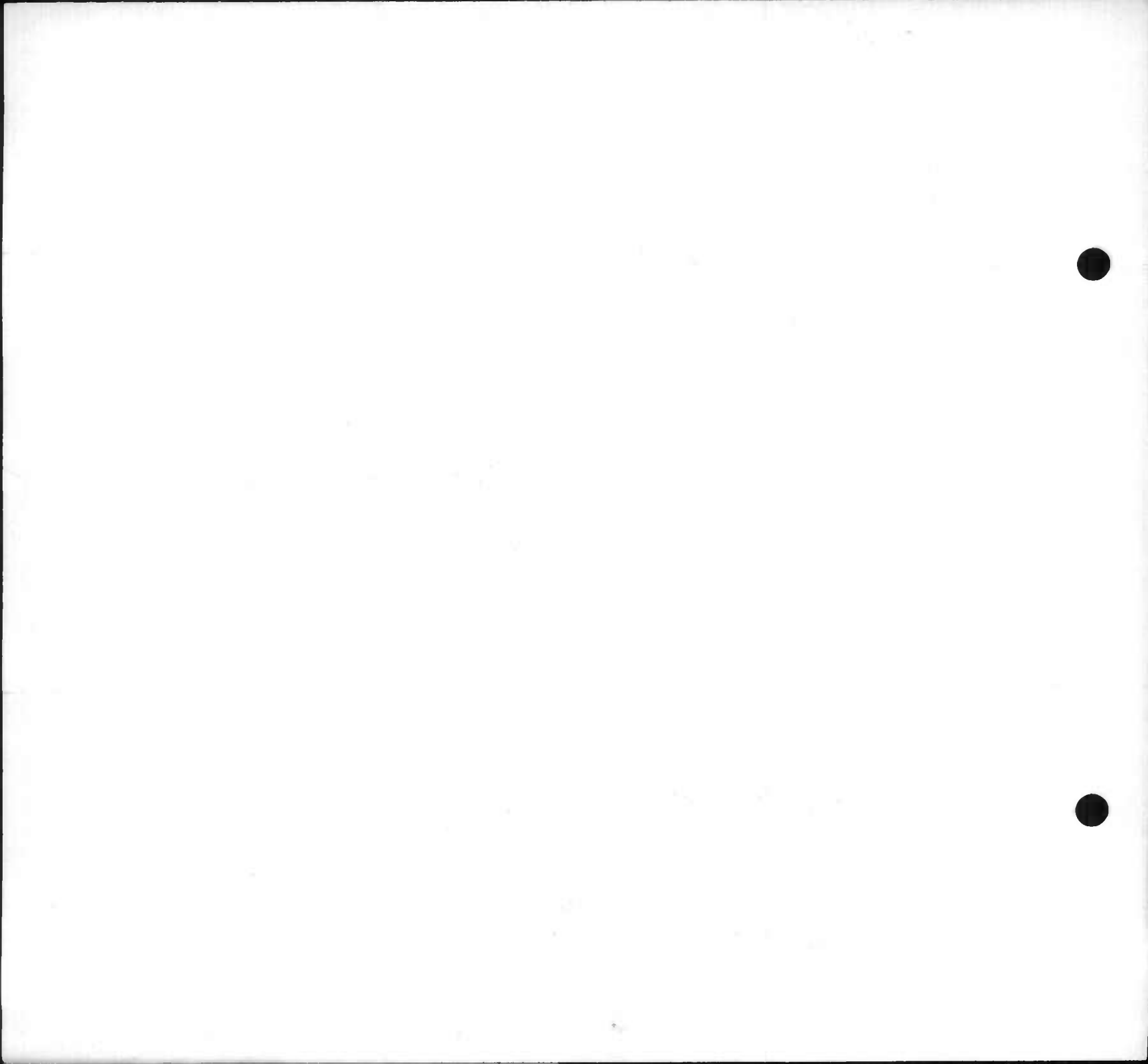
G-650 71 8534		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8534	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Johnnie Daniel Green		Sept. 8, 1971 6:10A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
US Public Health Service Hospital 2X 3100 Wyman Parkway			Md. 203		
5. SEX			6. DATE OF BIRTH		
M W			9/9/14		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) 56		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Oiler			Texas		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Seafarer			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Daniel B. Green			Clara Cass		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			450-09-6108		
17. INFORMANT			ADDRESS		
Records- US PHS Hospital, Balto, Md.					
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Bilateral focal pneumonia		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Broncho-esophageal fistula		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Carcinoma of esophagus		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
yes			yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 9 1971 to Sept. 8 1971 that (I) (we) last saw the deceased alive on Sept. 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Robert E. Belliveau MD (Surg)			9/8/71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Robert E. Belliveau, Surg (R)			US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-10-1971		Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
Glen Burnie, Anne Arundel Co., Md.		Howard H. Hubbard, 4107 Wilkens Ave. 21229			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
SEP 13 1971		Robert E. Belliveau, M.D.		4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

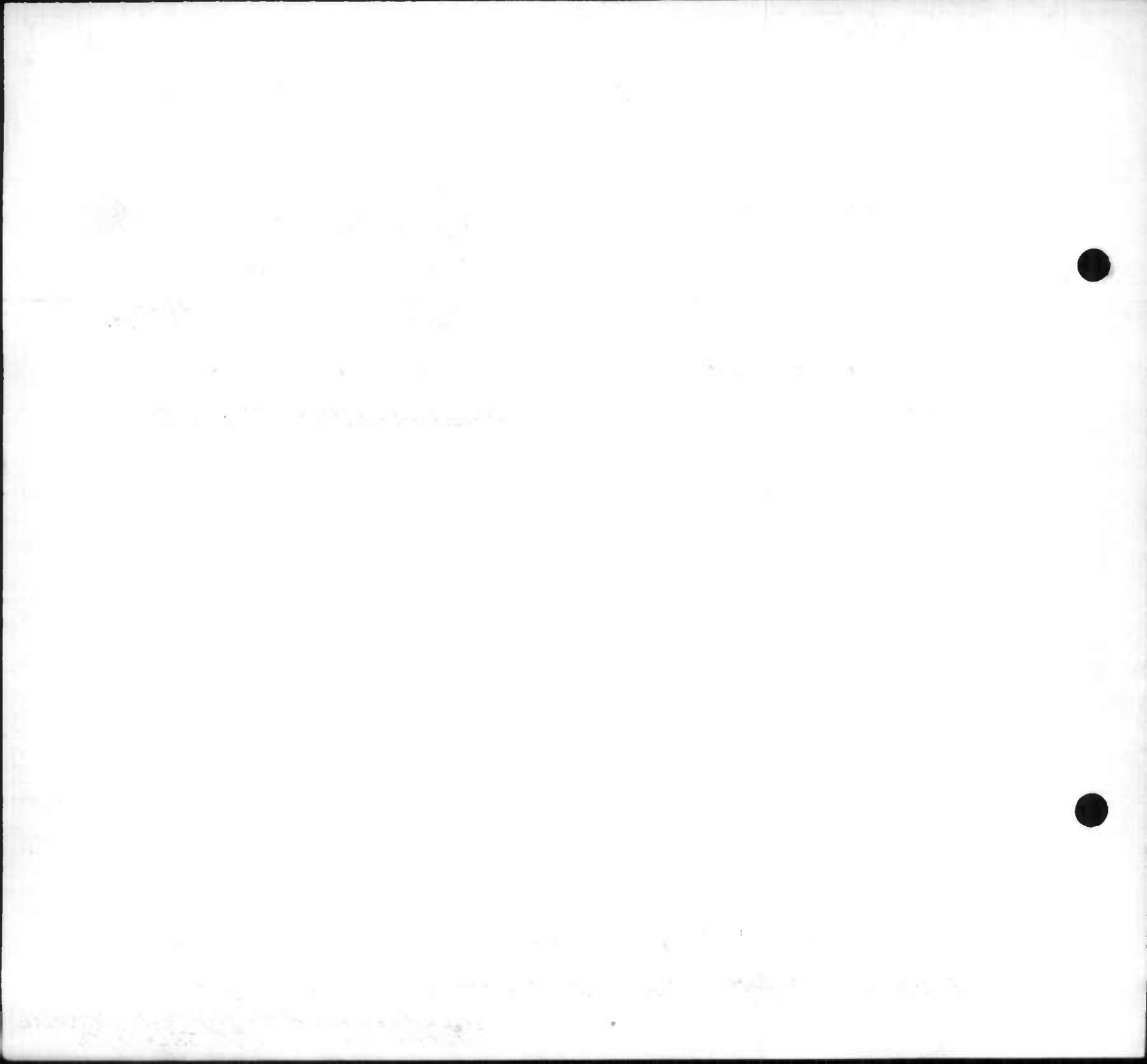
BIRTH NO. <u>71 8535</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8535</u>	
1. NAME OF DECEASED (Type or Print) <u>Marie C. Seibert</u>			2. DATE AND HOUR OF DEATH <u>9/9/71</u> <u>9 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1902</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hosp.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>328 S. Stricker</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/6/1912</u>	9. AGE (In years last birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Lawrence, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Lottie Best</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mr. Howard Seibert</u>	
ADDRESS <u>above</u>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary thrombosis, probable</u>					
(B) DUE TO OR AS A CONSEQUENCE OF: <u>Hypertension</u>					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 16</u> 19 <u>66</u> to <u>Present</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>For W.K. Gallagher, Jr., M.D.</u>				23B. DATE SIGNED <u>10 September 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>For W. K. Gallagher, Jr., M.D.</u>				23D. ADDRESS <u>3455 Wilkens Avenue - 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Gowan & Son Inc.</u>	
ADDRESS <u>23. Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

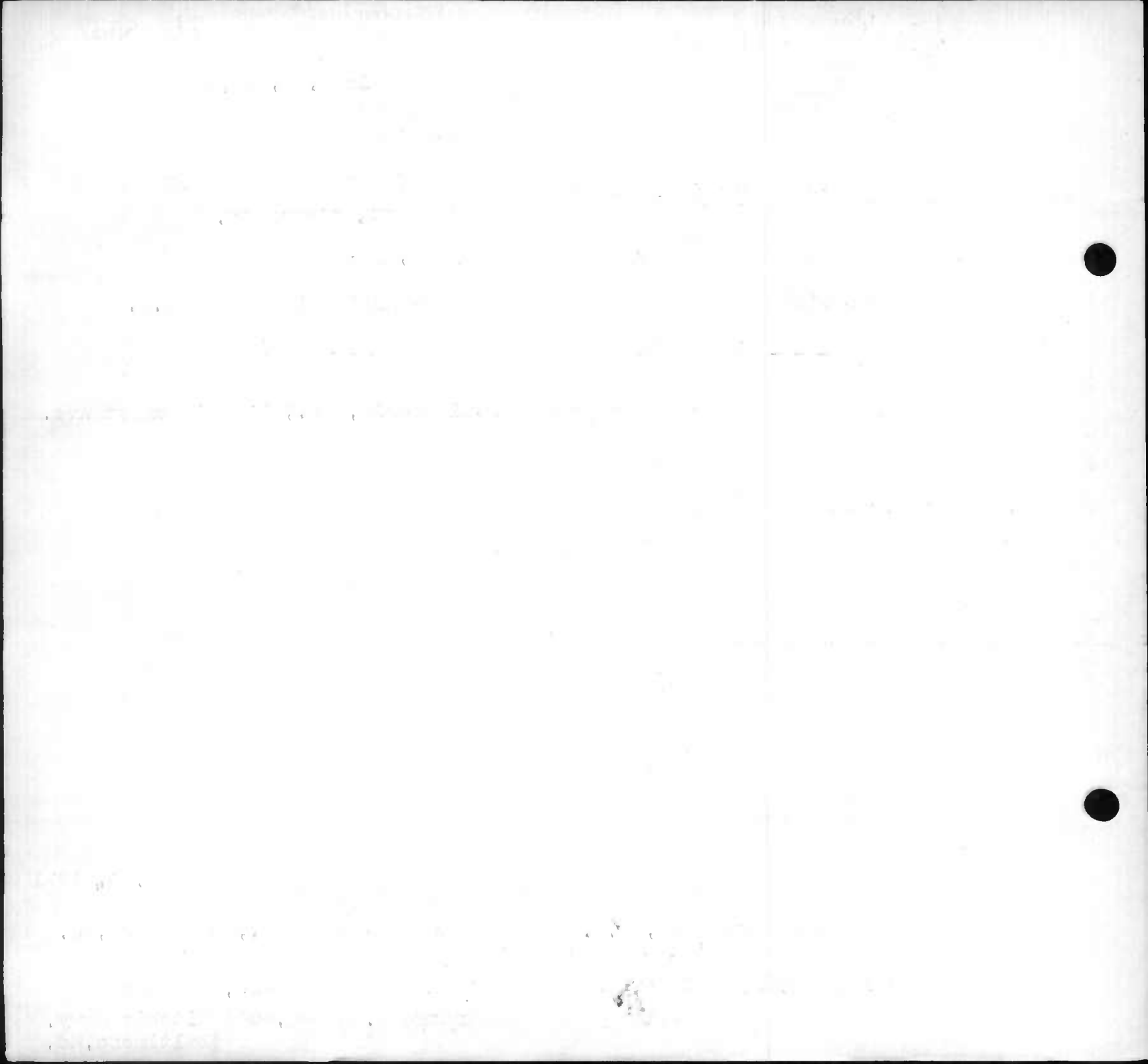
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 8536</u>	
0-36571 8536 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Neo Esther Odoran</u>		2. DATE AND HOUR OF DEATH <u>9/9/71 7:15</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Ohio</u> B. COUNTY <u>V 32</u> C. CITY OR TOWN <u>Salem</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>763 Lincoln Avenue 44460</u>			
5. SEX <u>Female</u>	6. RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/06/93</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Rummel, Deemern H.</u>			
14. MOTHER'S MAIDEN NAME <u>Schlosser, Leonia A.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no.</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>JACK MEMORIAL INC., JALEM, O.</u> ADDRESS			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Septis, Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
(B) <u>Leucopenia</u> DUE TO, OR AS A CONSEQUENCE OF:			(C)		<u>5 days</u>
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/7</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> 19 <u>71</u> to <u>9/9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Karen O'Neill</u>				23B. DATE SIGNED <u>9/9/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Karen O'Neill, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL REMOVAL</u>		24B. DATE <u>9-11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>GRAND VIEW CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>JALEM, OHIO</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>USE RICH FUNERAL HOME</u>			
25D. ADDRESS <u>16420, IND.</u>		25E. ADDRESS <u>JACK MEMORIAL JALEM, O.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

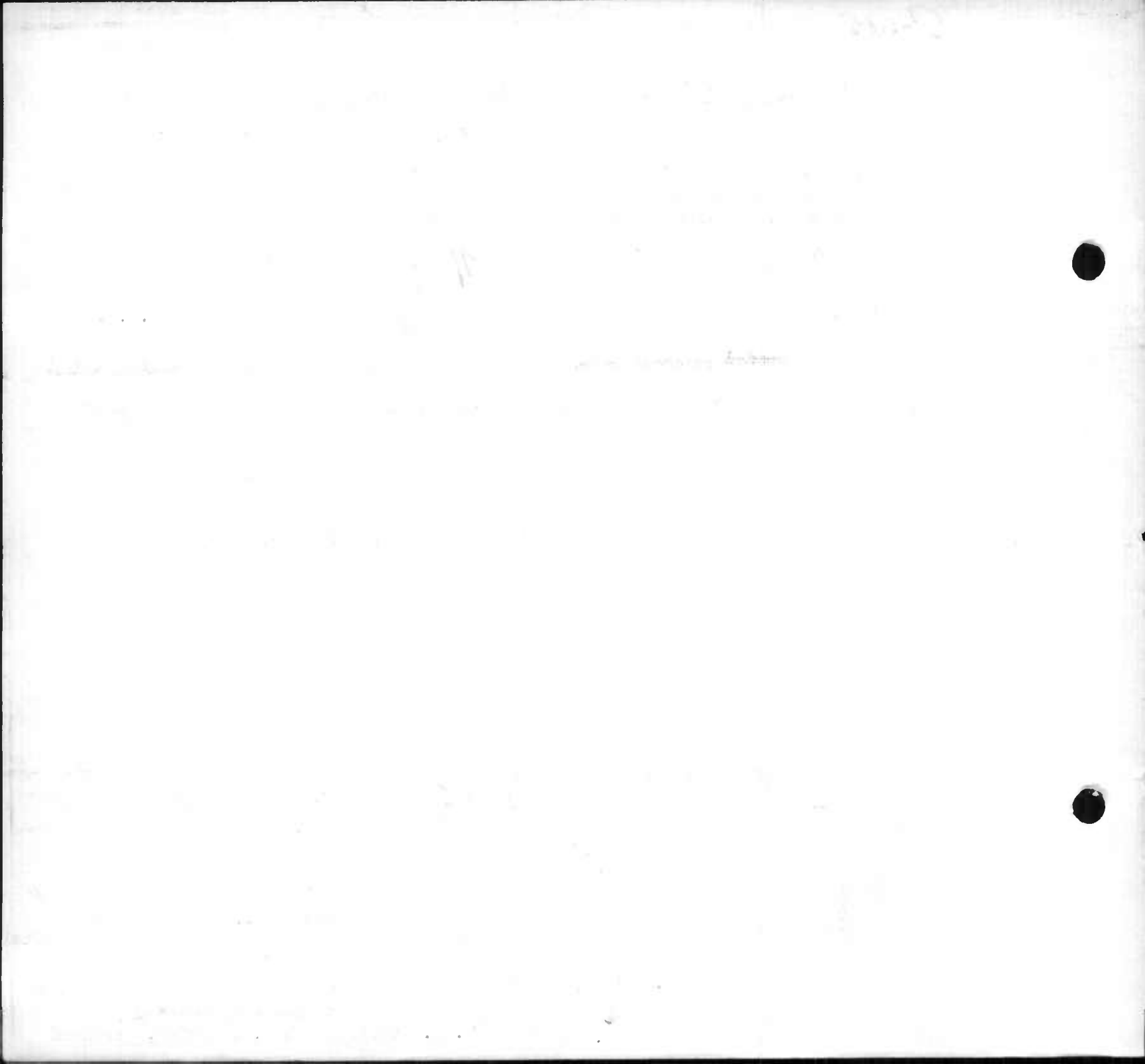
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8537	
L-600 71 8537		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELLA LERIE		2. DATE AND HOUR OF DEATH Sept. 7, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3806 St. Victor St.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 69	11. BIRTHPLACE (State or foreign country) Pennsylvania
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME McCracken		14. MOTHER'S MAIDEN NAME Orbin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Louis Lerie, Jr., 306 Hillcrest Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Rot. scler. heart disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bronchial asthma. Congestive heart failure		(B) DUE TO, OR AS A CONSEQUENCE OF: Bronchial asthma. Congestive heart failure	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Imre Neubauer M.D.			23B. DATE SIGNED Sept. 7, 1971
23C. PHYSICIAN'S NAME (Type) Imre Neubauer, M.D.		23D. ADDRESS 936 Patapsco Ave., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/10/1971	24C. NAME OF CEMETERY or CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.	25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy. Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

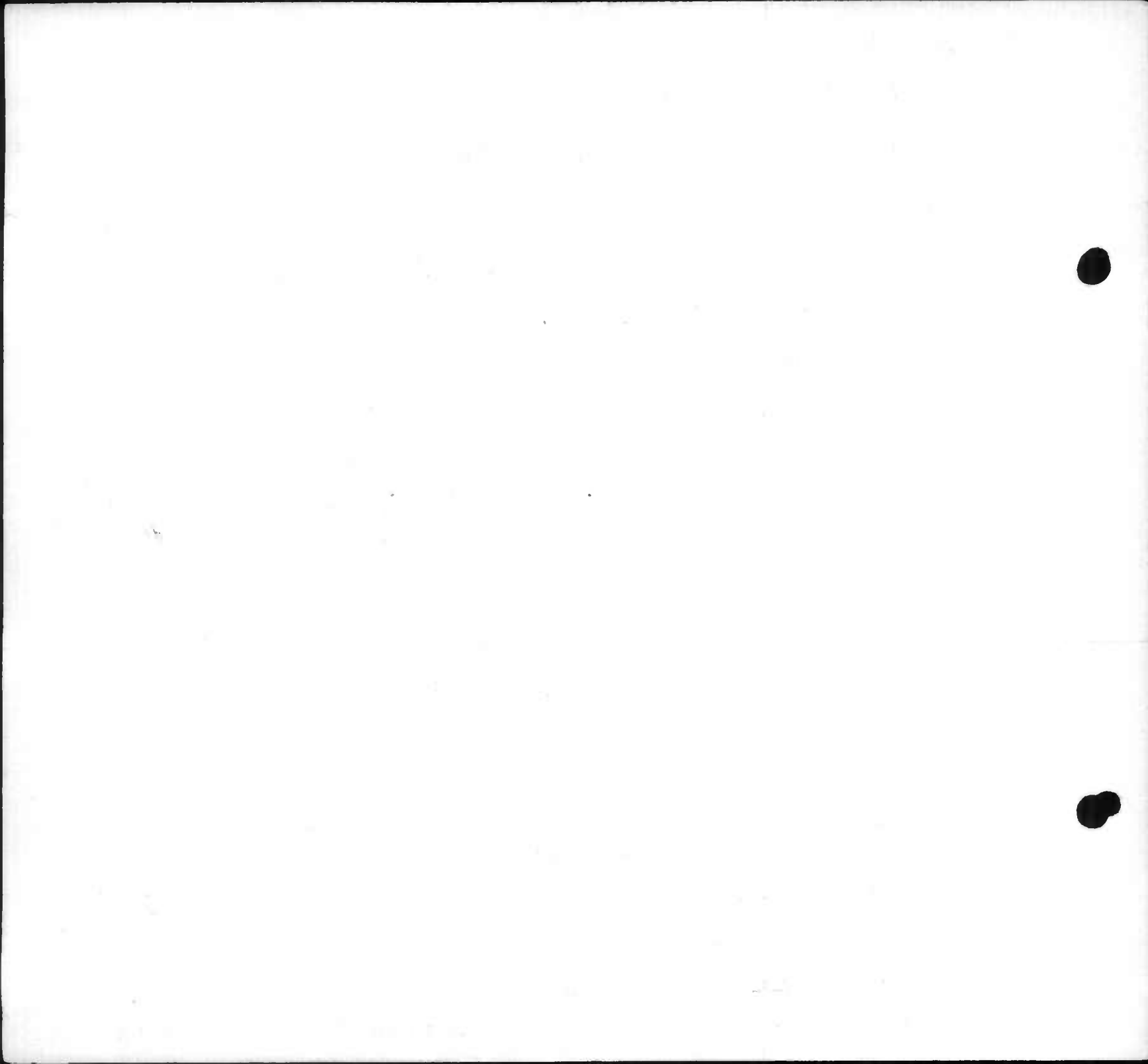
C-615 71 8538		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 8538	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Carpenter, Elizabeth Virginia</i>			
2. DATE AND HOUR OF DEATH <i>9 September 1971 11:40 P</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Frederick</i>				5. CITY OR TOWN <i>Frederick</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. STREET AND NUMBER <i>Rt 1</i>				7. ZIP CODE <i>21701</i>			
5. SEX <i>Female</i>		6. RACE <i>Cauc</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/25/14</i>	
9. AGE (in years last birthday) <i>57</i>		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Daniel Webster Wolfe</i>				14. MOTHER'S MAIDEN NAME <i>Cora Virginia Baker</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Records: BCH-4940 Eastern Avenue</i>				ADDRESS <i>21224</i>			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE <i>Gram Negative Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF:							
(B) <i>Acute Myelogenous Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>9 Sept</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4 September 1971</i> to <i>9 September 1971</i> that (I) (we) last saw the deceased alive on <i>9 Sept</i> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Gary M Kammer MD</i> DEGREE				23B. DATE SIGNED <i>9 September 1971</i>			
23C. PHYSICIAN'S NAME (Type) <i>Gary M Kammer MD</i> DEGREE				23D. ADDRESS <i>601 N. Broadway Balt, Md Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/13/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>McKaig Frederick Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Donald M. Adick</i> ADDRESS <i>M. R. Etchison & Son, Frederick, Maryland</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

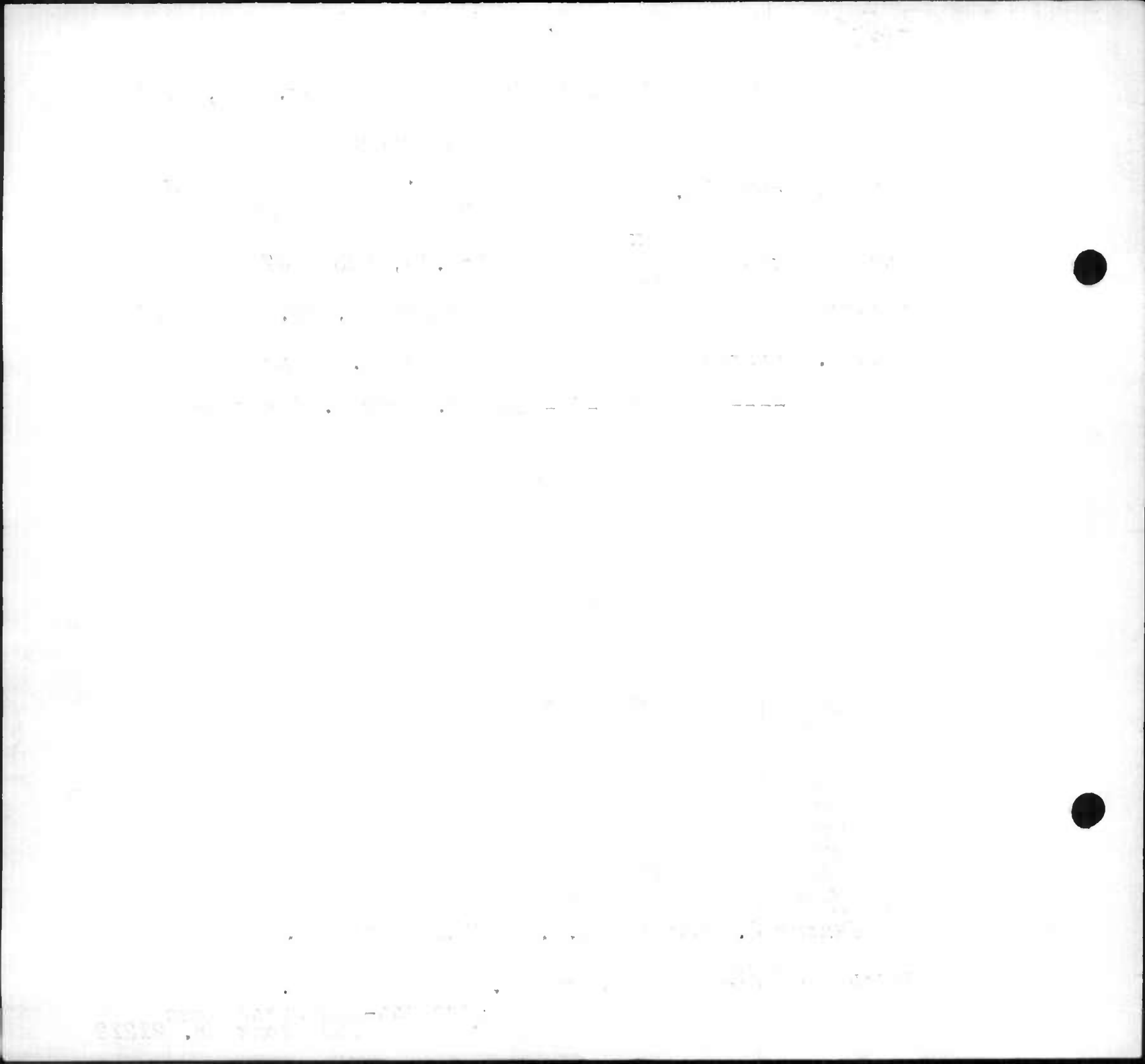
L-300 71 8539		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8539	
1. NAME OF DECEASED (Type or Print) LLOYD HARRY S.		2. DATE AND HOUR OF DEATH 9/5/71 12:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 71 MONTEBELLO STATE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALT. CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 71 MONTEBELLO STATE HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-retired		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker MFG.		8. DATE OF BIRTH 10/1/1899	
13. FATHER'S NAME John Lloyd		14. MOTHER'S MAIDEN NAME Bell Bull		9. AGE (In years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 212-10-9596		11. BIRTHPLACE (State or foreign country) Maryland	
		17. INFORMANT Family records		12. CITIZEN OF WHAT COUNTRY? USA	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA OF COLON METASTATIC TO SPINE		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (WITH) CARCINOMA METASTATIC TO THORACIC SPINE		3 1/2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CARCINOMA METASTATIC TO THORACIC SPINE DUE TO, OR AS A CONSEQUENCE OF: (C)		4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ARTERIO SCLEROTIC HEART DISEASE		?	
19A. DATE OF OPERATION 6/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PARAPLEGIA 2° (B)		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/3/71 19__ to DEATH 19__ that (1) (we) last saw the deceased alive on 9/5 19__ and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.					
23A. SIGNATURE Joseph Kenneth Marshall, Jr. M.D.		23B. DATE SIGNED 9/5/71		23C. PHYSICIAN'S NAME (Type) JOSEPH KENNETH MARSHALL, JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-9-71		24C. NAME OF CEMETERY OR CREMATORY Jessops Cemetery	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Patricia E. Taylor, M.D.		25C. FUNERAL DIRECTOR John Burns Sons	
				ADDRESS Towson	



FUNERAL DIRECTOR: IMPORTANT

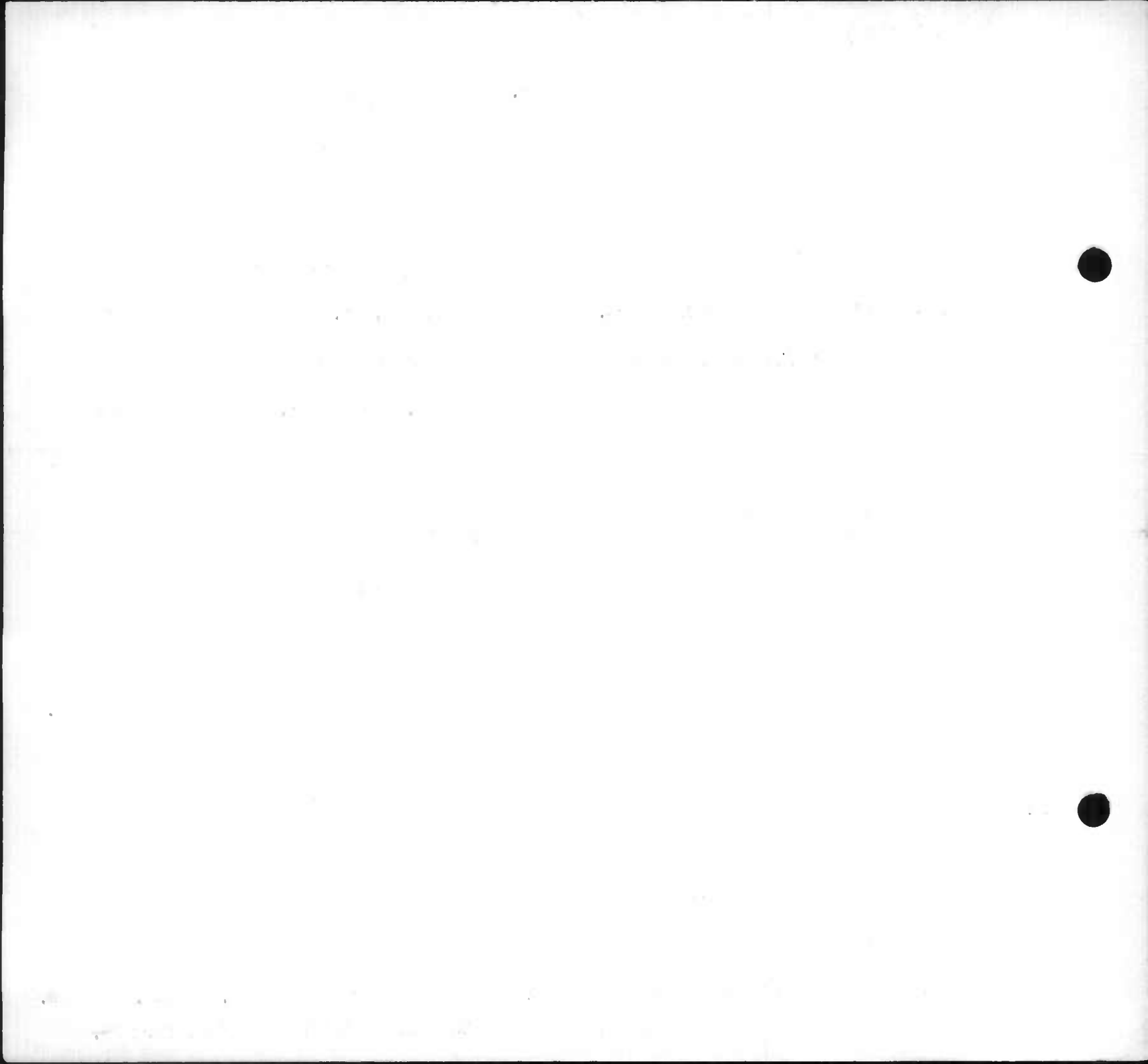
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8540</u>	
<p><u>S-415</u> <u>71 8540</u></p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>JOSEPH HEALY SULLIVAN</u></p>		<p>2. DATE AND HOUR OF DEATH <u>SEPT. 6TH, 1971 3 30 PM.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2102 1/2 SOUTH RD.</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2755</u></p> <p>C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2102 1/2 SOUTH ROAD</u></p>		
<p>5. SEX <u>MALE</u> 6. RACE <u>WHITE</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>OCT. 15, 1925</u> 9. AGE (In years last birthday) <u>47</u></p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>FROSTBURG, MD.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>			<p>13. FATHER'S NAME <u>JOHN A. SULLIVAN</u></p>		
<p>14. MOTHER'S MAIDEN NAME <u>SUSAN M. HEALY</u></p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		
<p>16. SOCIAL SECURITY NO. <u>215-20-5201</u></p>		<p>17. INFORMANT ADDRESS <u>Mrs. ANNE B. SULLIVAN</u></p>			
<p>18. <u>196.01</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Squamous Cell Ca of Tongue</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>9-5 1971</u> to <u>9-6 1971</u> that (I) (we) last saw the deceased alive on <u>9-6 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Jerome J. Coller</u> DEGREE</p>				<p>23B. DATE SIGNED <u>9/8/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>Jerome J. COLLER M.D.</u> DEGREE</p>				<p>23D. ADDRESS <u>2217 SOUTH RD.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>9/9/71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>WOODLAWN CEM.</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>BALTO.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u></p>			
<p>25B. NAME OF REGISTRAR <u>Reese J. ...</u></p>		<p>25C. FUNERAL DIRECTOR <u>WIEDEFELD HOME</u> ADDRESS <u>6500 YORK RD. 21212</u></p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8541	
BIRTH NO. 71 8541		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GOODHUSE, GEORGE S. Sr.</u>		2. DATE AND HOUR OF DEATH <u>9/6/71</u> <u>5⁰⁵</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MD. GENERAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO. CITY</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1603 E. 33RD ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/26/87</u>	9. AGE (In years last birthday) <u>84</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ship Maint.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Ferdinand Goodhuse</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Douglas</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-28-1026</u>		17. INFORMANT ADDRESS <u>George S. Goodhuse Jr. 106 Homeland Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca MORTATE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>JUNE 71</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD + CEREBRAL INSUFFIC.</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>HEART FAILURE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/6/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> 19 <u>71</u> to <u>9/6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond V. H.</u>		23B. DATE SIGNED <u>9/6/76</u>		23C. PHYSICIAN'S NAME (Type) <u>Raymond V. H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/8/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Cathedral Cemetery</u>	
24D. LOCATION <u>Frederick Rd. Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>	
25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>		25D. ADDRESS <u>6500 York Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8542

P-652 71 8542

BIRTH NO. 1

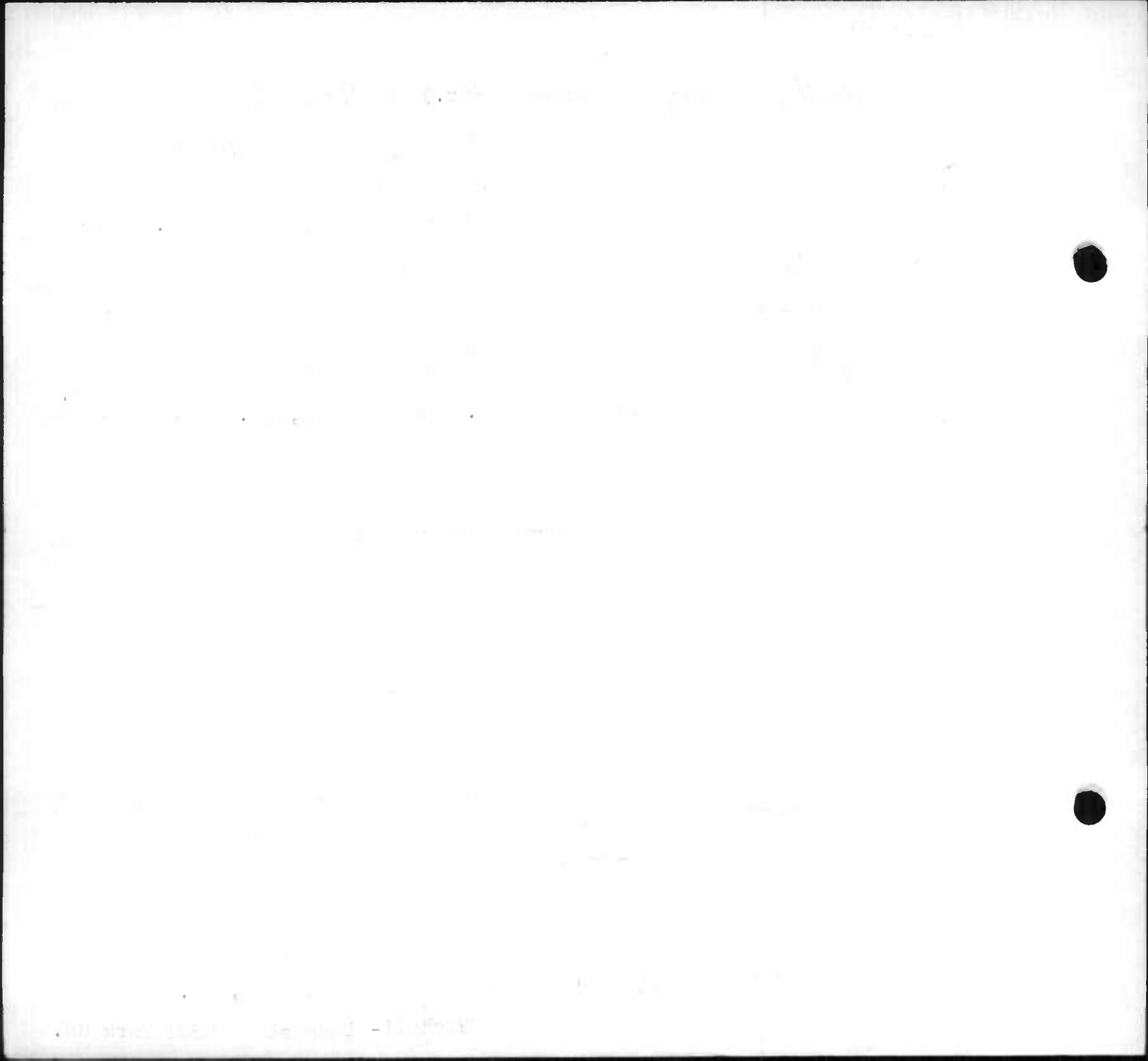
1. NAME OF DECEASED (Type or Print) <u>King - Mrs. Emma O.</u>		2. DATE AND HOUR OF DEATH <u>9-8-71 12:30 a. m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>700 West 40th Street</u>	
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1893</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>78</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Orem</u>		14. MOTHER'S MAIDEN NAME <u>Emma White</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-1139</u>	17. INFORMANT <u>Keswick Records</u>
18. <u>7109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>9-8-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>RK Gundry</u>		23B. DATE SIGNED <u>9-8-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard K. Gundry, MD</u>		23D. ADDRESS <u>700 West 40th Street, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/10/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Mitchell Wiedefeld</u>	
25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		ADDRESS <u>Home 6500 York Rd.</u>	

Adm. 7/20/70

310E 33rd St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

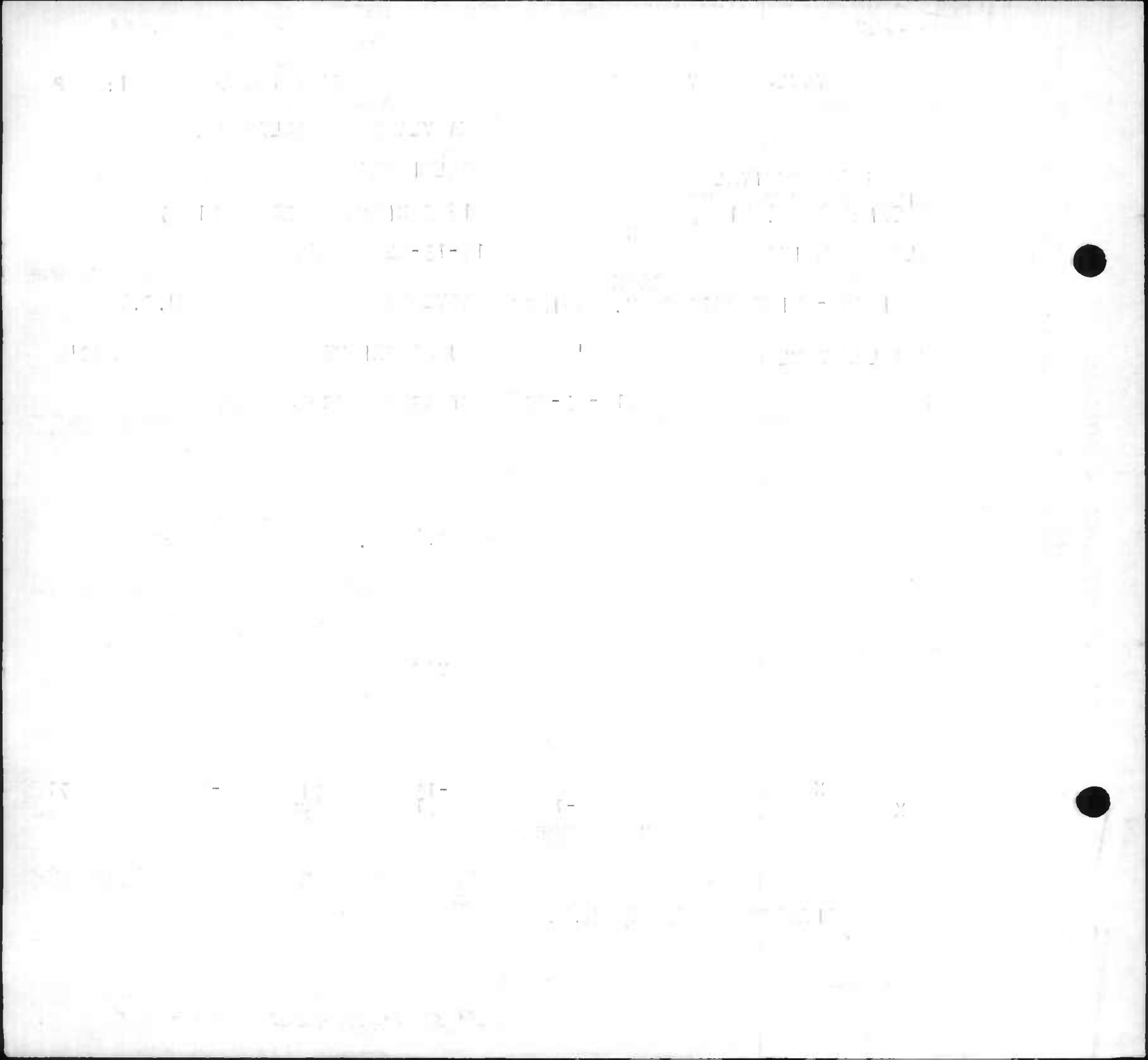
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
H-400 71 8543				71 8543	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Hull, Harry Bernard (Sr.)		9-6-71		3 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
North Charles General Hospital		Maryland		21228 5300	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		Birdwood & Smithwood Aves.		21228	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-21-1901	70	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Self Employed		Wholesale Candy		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Harry B. Hull		Cora Musser		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		216-01-1238		H. Bernard Hull, Jr. 1113 Ramblewood Rd.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		1 day	
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Marked atherosclerosis coronary artery, heart			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		Yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		9-1-71		19-71 to 9-6-71	
that (I) (we) last saw the deceased alive on		9-6-71		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
B.C. Veneracion Jr.		Sept 6, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
B.C. VENERACION JR.		NORTH CHARLES GEN HOSP DR			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/9/71		Leister's Cemetery	
		24D. LOCATION (City, town, or county)		(State)	
		Westminster, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 13 1971		Robert E. Taylor, M.D.		Mitchell-Wiedefeld	
				ADDRESS	
				6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

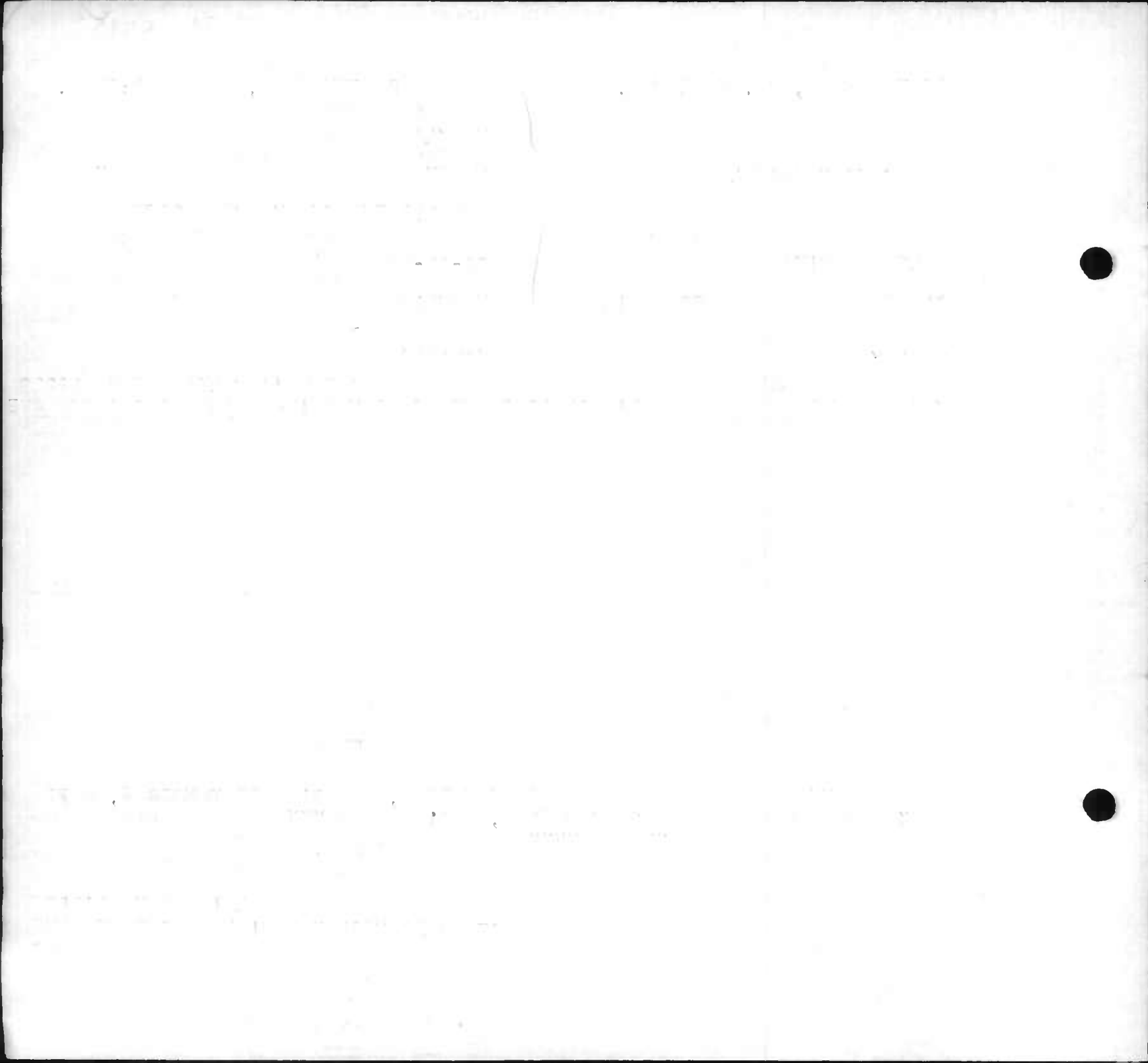
T-460 71 8544		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8544	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) TAYLOR, RAYMOND S		2. DATE AND HOUR OF DEATH SEPT 10, 71 1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO CO.		5.300	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE, MD. 21207		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1605 KIRKWOOD RD 21207		6. DATE OF BIRTH 10-13-02		9. AGE in years (last birthday) 68	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY BANK		11. BIRTHPLACE (State or foreign country) MARYLAND	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - VICE PRES PROV. SAVINGS		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME CHARLES TAYLOR DEC'D		14. MOTHER'S MAIDEN NAME JANE SKIRVEN DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-03-5964		17. INFORMANT ADDRESS ST AGNES RECORD ROOM	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Bilateral pulmonary infarction.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Primary myocardial insufficiency DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 08-13 to 9-10 19 71 that (X) (we) last saw the deceased alive on 9-10 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.					
23A. SIGNATURE E. Henzan M.D.		23B. DATE SIGNED 9/10/1971			
23C. PHYSICIAN'S NAME (Type) E. HENZAN M.D.		23D. ADDRESS St Agnes Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 9/13/71		24C. NAME OF CEMETERY OR CREMATORY MT. OLIVET	
24D. LOCATION BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR A.S. MACNABE	
25C. FUNERAL DIRECTOR 212-28					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8545	
1. NAME OF DECEASED (Type or Print) LEATHERWOOD, JR. MORLEY H.		2. DATE AND HOUR OF DEATH SEPTEMBER 8, 1971 4:17 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND HOWARD 6300 B. COUNTY C. CITY OR TOWN HANOVER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER BOX 271 FOREST AVENUE 21076			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-12-23		9. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY C&O RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MORLEY H. LEATHERWOOD JR.			
14. MOTHER'S MAIDEN NAME (SMITH)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2			
16. SOCIAL SECURITY NO. 219 12 3380		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from SEPTEMBER 8, 19 71 to SEPTEMBER 8, 19 71 that II (we) last saw the deceased alive on SEPTEMBER 8, 19 71 and that IX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XXXX view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/11/71		24C. NAME OF CEMETERY OR CREMATORY ZION	
24D. LOCATION (City, town, or county) (State) HOWARD CO. MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971			
25B. NAME OF REGISTRAR R. E. [Signature]		25C. FUNERAL DIRECTOR A. S. [Signature]			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656 71 8546		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8546	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William E. Turner</u>		2. DATE AND HOUR OF DEATH <u>9/8/71</u> <u>3 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>House in the Pines - Catonsville</u> <u>Fusting Avenue</u> <u>Catonsville, Md. 21228</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>Ad.</u>	
		C. CITY OR TOWN <u>Churchton</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1920</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cyberman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Arthur Turner</u>		14. MOTHER'S MAIDEN NAME <u>Marie Blaney</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Susie Davis Churchton</u> ADDRESS	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Carcinoma of the</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>Stomach with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 yrs.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8/26</u> 19 <u>71</u> to <u>9/8</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>9/8</u> 19 <u>71</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Herbert J. Levickas M.D.</u>		23B. DATE SIGNED <u>9/10/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas, M.D.</u>		23D. ADDRESS <u>5404 East Drive Baltimore Md 21227</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-11-1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Franklin Deale</u>	
24D. LOCATION (City, town, or county) <u>MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>John E. Jones</u>		25C. FUNERAL DIRECTOR <u>William Reese</u> ADDRESS <u>Charm</u>	

2

x

Mr. J. W. Harrison

12 051-1-P x

A.2.N

Mr.

Arthur W. Harrison

Mr. J. W. Harrison
2nd Avenue
New York City

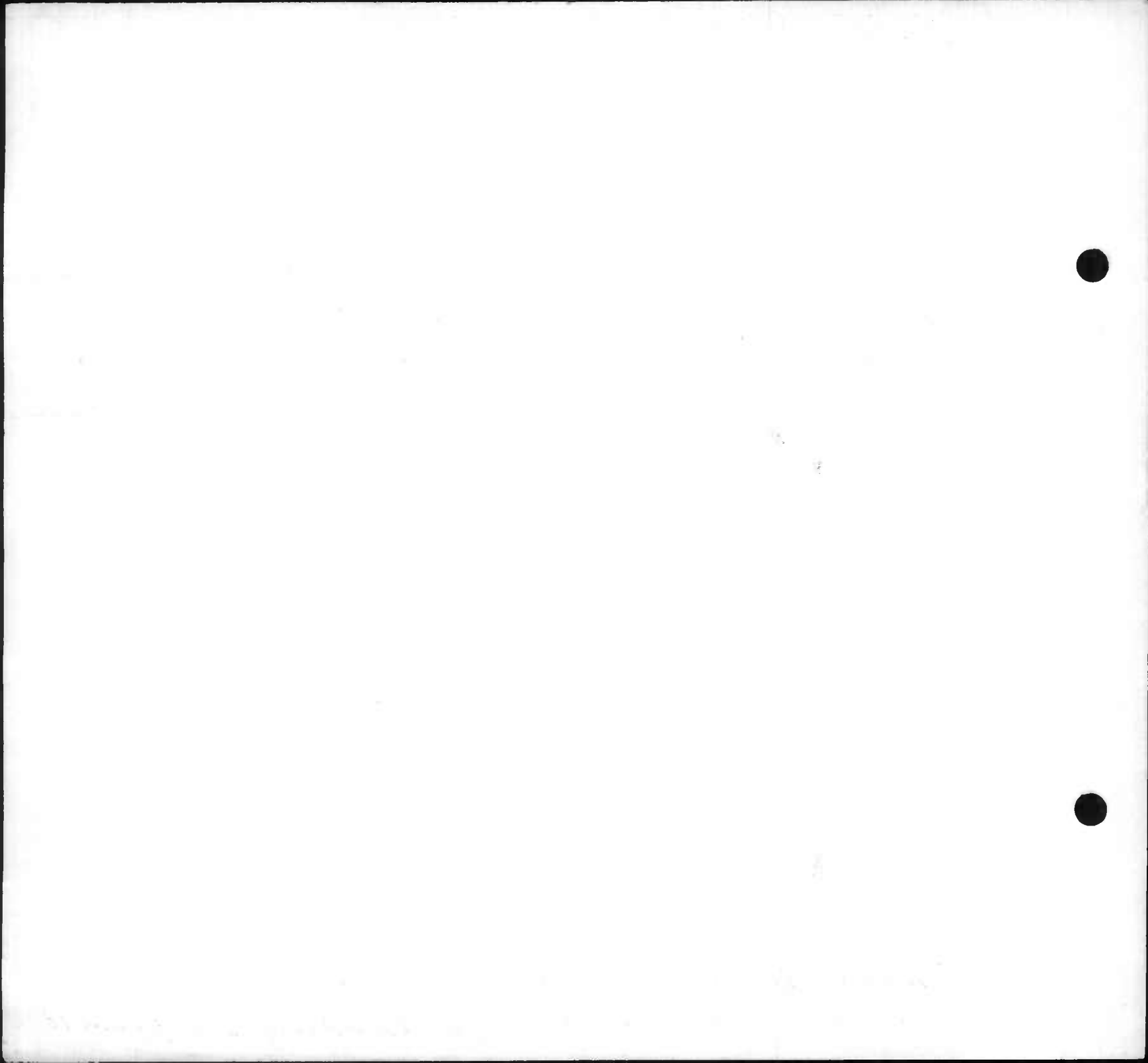
Mr. J. W. Harrison

Mr. J. W. Harrison
2nd Avenue
New York City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-151 71 8547		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8547	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BERTHA DAVENPORT</u>		2. DATE AND HOUR OF DEATH <u>9/9/71</u> <u>1 3 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1601</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 MONTEBELLO STATE HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>	6. RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1891</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis A Davenport</u>		14. MOTHER'S MAIDEN NAME <u>J. Hy</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Barbara J. Barnes 1115 Harlan Ave</u>	
18. <u>1538</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ADENOCARCINOMA OF COLON METASTATIC</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 MONTHS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>8-3</u> 19 <u>71</u> to <u>9-9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Elex M. Jones</u>		23B. DATE SIGNED <u>9-9-71</u>		23C. PHYSICIAN'S NAME (Type) <u>G. FUXA</u>	
23D. ADDRESS <u>MONTEBELLO STATE HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-2-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>at Home</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Barbara J. Barnes</u>		25D. ADDRESS <u>1115 Harlan Ave</u>	



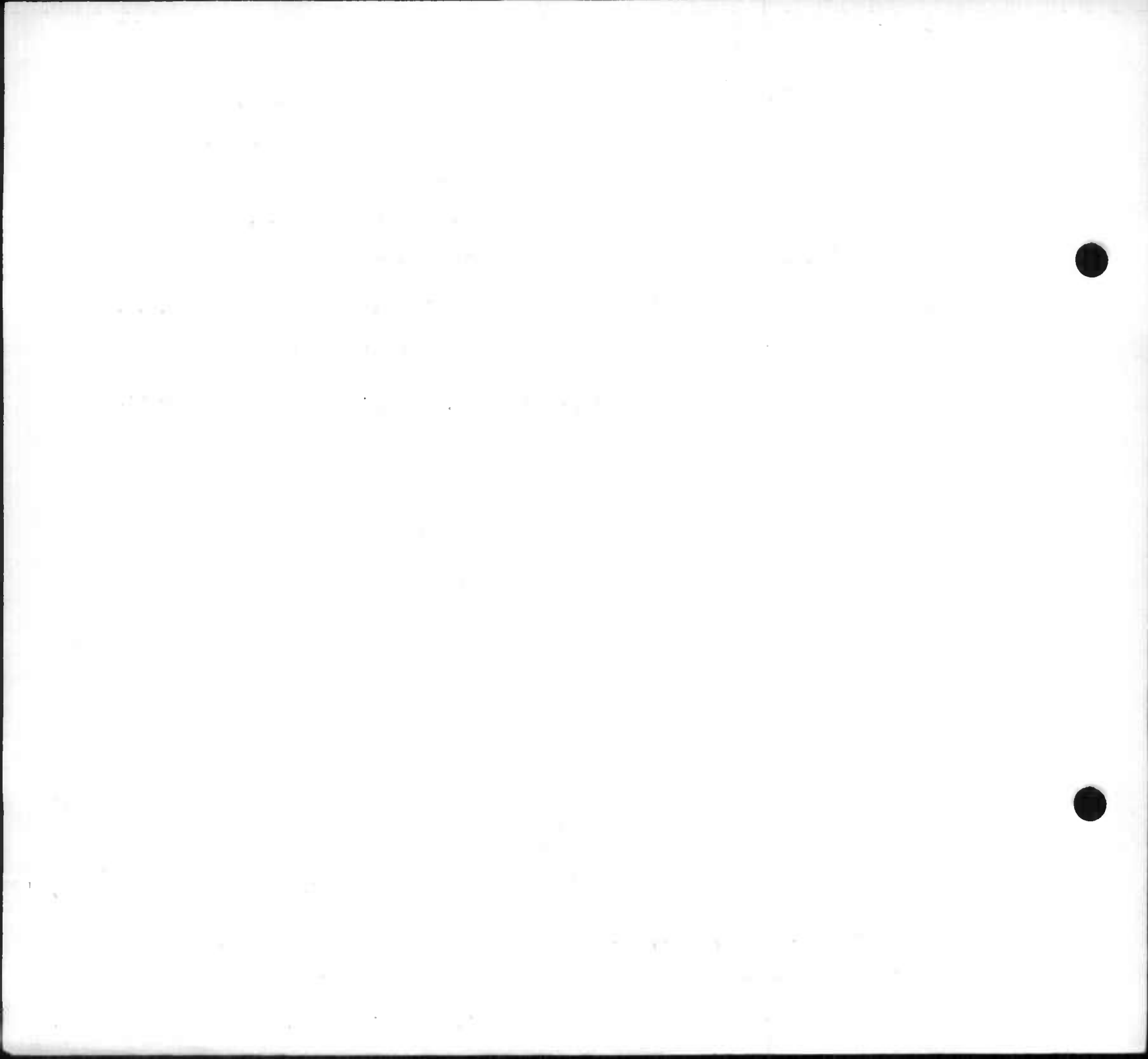
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-5301</u> <u>8548</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>8548</u>	
1. NAME OF DECEASED (Type or Print) <u>Edward William Smith</u>			2. DATE AND HOUR OF DEATH <u>27 August 1971</u> <u>9³⁰ P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>3323 W. Garrison St.</u> <u>Baltimore, Md.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>—</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3323 West Garrison St.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 NOV 1925</u>	9. AGE (in years last birthday) <u>45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter's helper</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>James Smith</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Yes</u> <u>1940's</u>		16. SOCIAL SECURITY NO. <u>218-18-1427</u>		17. INFORMANT <u>Ruth Nash (sister) - 3323 W. Garrison St. Baltimore Md</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u> <u>2 years</u> <u>?</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Multiple bone infarcts</u>					
19A. DATE OF OPERATION <u>3/9/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fibrosarcoma left tibia</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u>	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>February</u> 19 <u>70</u> to <u>August</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5 August</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Haddox Sothoron MD</u>			23B. DATE SIGNED <u>28 August 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>W. Haddox Sothoron MD</u>			23D. ADDRESS <u>University of Maryland Hospital, Baltimore, Md.</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-1-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carron Mem. Park Laurel Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR <u>William H. Chaniz</u>		25D. ADDRESS <u>1422 Edmond Ave</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>7-563 71 8549</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8549</p>	
<p>BIRTH NO. 7-563 71 8549</p> <p>1. NAME OF DECEASED (Type or Print) G. James Finnerty</p>		<p>2. DATE AND HOUR OF DEATH September 9, 1971 11:00 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD THE GOOD SAMARITAN HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 21224</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE GOOD SAMARITAN HOSPITAL</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
		<p>E. STREET AND NUMBER 7314 Berkshire Rd.</p>	
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 04-23-99</p>
<p>9. AGE (in years last birthday) 72</p>		<p>If Under 1 Yr. Months Days</p>	<p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Ship Fitter</p>	
<p>11. BIRTHPLACE (State or foreign country) Baltimore, Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME John Finnerty</p>		<p>14. MOTHER'S MAIDEN NAME Margaret Cooney</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 216-07-6589</p>	
<p>17. INFORMANT Mrs. Frederick Krug</p>		<p>ADDRESS 7314 Berkshire Road</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
		<p>(A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF:</p>	
		<p>(B) Bilateral Pneumonia DUE TO, OR AS A CONSEQUENCE OF:</p>	
		<p>(C) Cancer of lung with effusions DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cancer of tongue and esophagus</p>		<p>5 years</p>	
<p>19A. DATE OF OPERATION none</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none</p>	
<p>20A. AUTOPSY? (Yes or No) Yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) xxx</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) xxx</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) xxx</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? xxx</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from August 3 19 71 to September 9 19 71 that (I) (we) last saw the deceased alive on September 9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.</p>			
<p>23A. SIGNATURE George H. Sack, Jr., M.D.</p>		<p>23B. DATE SIGNED September 9, '71</p>	
<p>23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.</p>		<p>23D. ADDRESS 5601 Loch Raven Blvd, 21212</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 9-13-1971</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY New Cathedral</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Jaber, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.</p>		<p>ADDRESS 1901-07 Eastern Ave.</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8550</u>	
BIRTH NO. <u>6-250 71 8550</u>		1. NAME OF DECEASED (Type or Print) <u>JAMES, V. GASKIN</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO		2. DATE AND HOUR OF DEATH <u>Sept. 12 - 1971</u> <u>12:10</u> <u>midnight</u> <u>A.M.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH Home & Hospital</u> <u>35</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21205</u> <u>603</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2227 JEFFERSON ST</u>			
5. SEX <u>MALE</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-09</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>61</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>SAMUEL GASKIN</u>		14. MOTHER'S MAIDEN NAME <u>AGNES MC INTYRE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>217-03-9022</u>	
17. INFORMANT <u>Mrs. Agnes Washel</u>		ADDRESS <u>2227 Jefferson St.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9-11-71-9-12-71</u> <u>MAY-Sept-71</u> <u>started 1969?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Recurrent pleural effusion</u>			
19A. DATE OF OPERATION <u>8-31-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cardiovascular shock</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED	
22. I certify that (I) (this hospital) attended the deceased from <u>8-31-71</u> <u>1971</u> to <u>9-12-71</u> <u>1971</u> that (I) (we) lost saw the deceased alive on <u>Sept. 12</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>MD DR Sajadi</u>		23B. DATE SIGNED <u>9-12-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR MOHAMMAD SAJADI Resident</u>		23D. ADDRESS <u>100 N. BROADWAY BALTIMORE 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-15-1971</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u>		ADDRESS <u>1901-07 Eastern Avenue</u>	

1

B-230 71

8551

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8551

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DONALD FARRELL BEST

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 9, 1971

8:53 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34 Bon Secours Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 9, 1971

8:53 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1783

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

851 George Street, #6D.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

WHAT COUNTRY?

13. FATHER'S NAME

Louie Best

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Pearl

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Ms Pearl Leggitt, 718 Linnard St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Sidewalk

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1104 W. Lexington St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

9-3-71

?

m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Presumably accidentally fell

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 9, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/13/71

24C. NAME of CEMETERY or CREMATORY

MT Auburn C metry

24D. LOCATION (City, town, or county)

A A County Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 13 1971

Robert E. Fisher, M.D.

Adolphus Halstead 1206 W North Ave

Letter from M.E.'s office

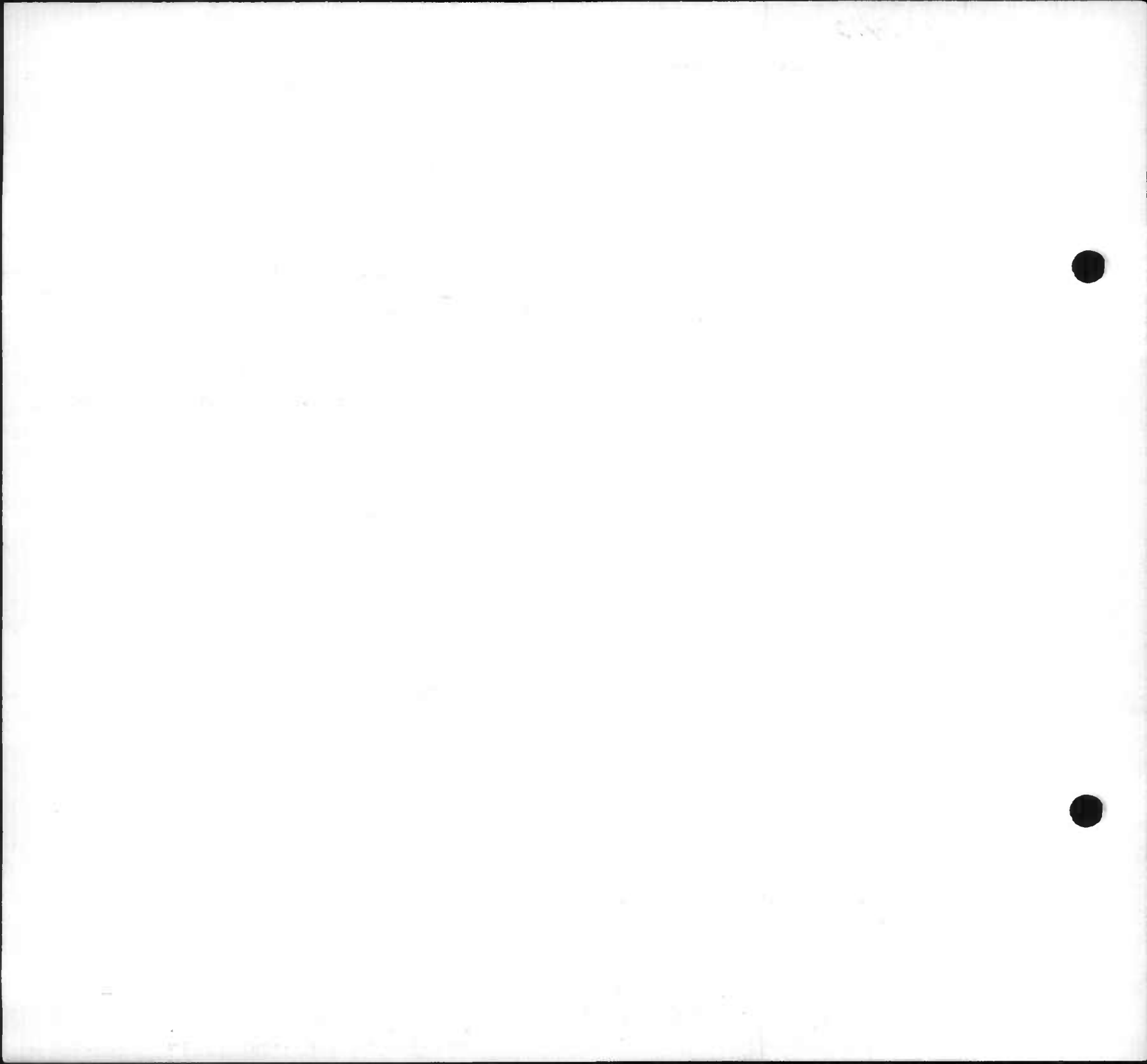
10-6-71 M.H.

ACADEMY BOND

FUNERAL DIRECTOR: IMPORTANT

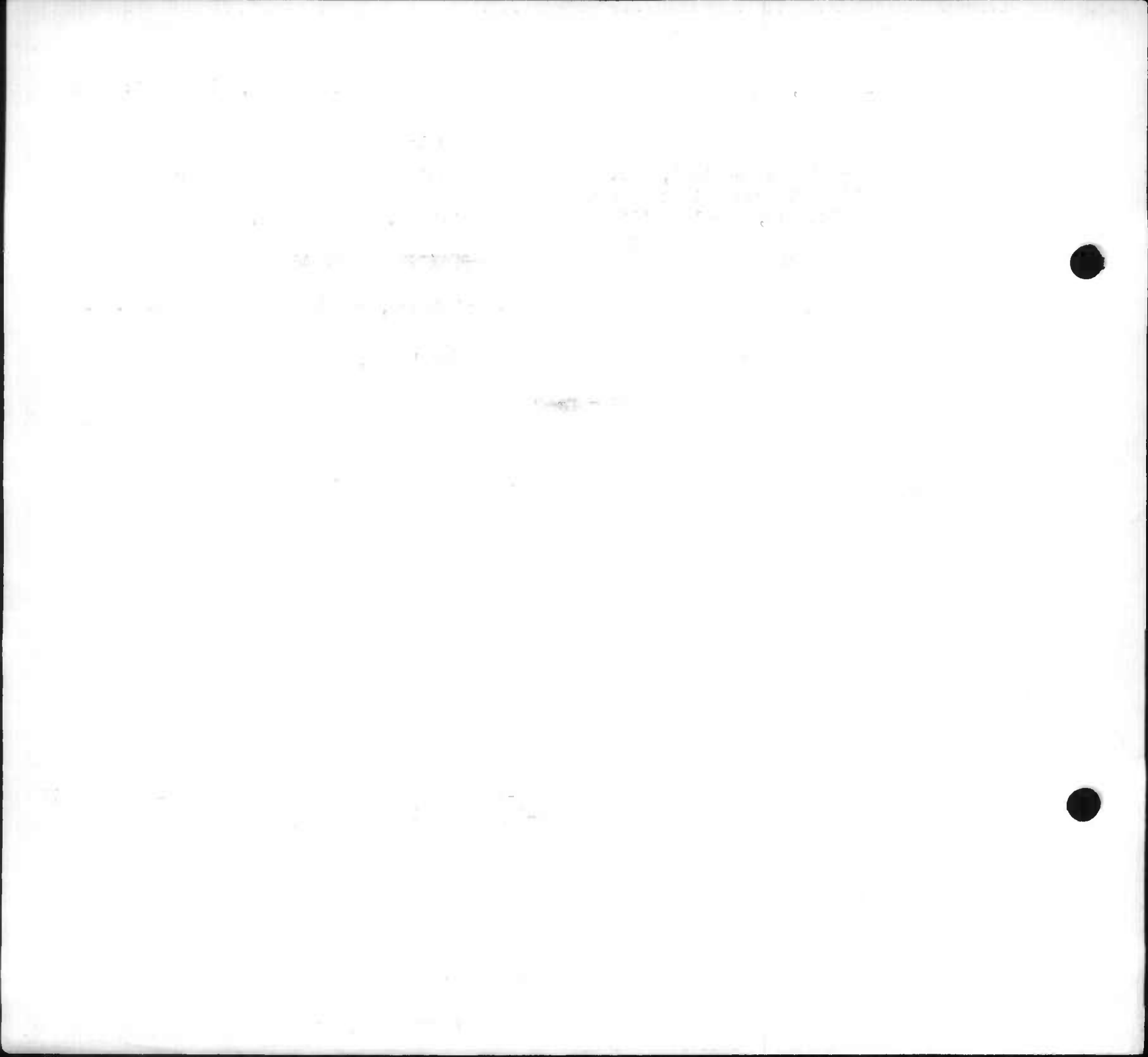
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8552</u>	
<div style="display: flex; justify-content: space-between;"> W-413 71 8552 </div>							
1. NAME OF DECEASED (Type or Print) <u>BARBARA ANNA WAHLHAUPTER</u>				2. DATE AND HOUR OF DEATH <u>8 SEPT 71 12 NOON M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MD GENERAL HOSP</u>				A. STATE <u>MD</u> B. COUNTY <u>1401</u>			
				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1615 Park Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886 7-22-XXXX</u>		9. AGE (In years last birthday) <u>85</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Frederick Huber</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Hoover</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>220 54-9325</u>		17. INFORMANT ADDRESS <u>Mrs Dorothy C. Cassidy 1824 Hope ST</u>	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Perforating gastric ulcer with peritonitis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>9-2-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-2-71</u> to <u>9-8-71</u> that (I) (we) last saw the deceased alive on <u>9-8-71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sherman Kahan MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9-8-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHERMAN KAHAN</u>				23D. ADDRESS <u>MD GEN HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/13/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT <u>SEP 13 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Henry Sander & Sons Inc. Baltimore Maryland 21213</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

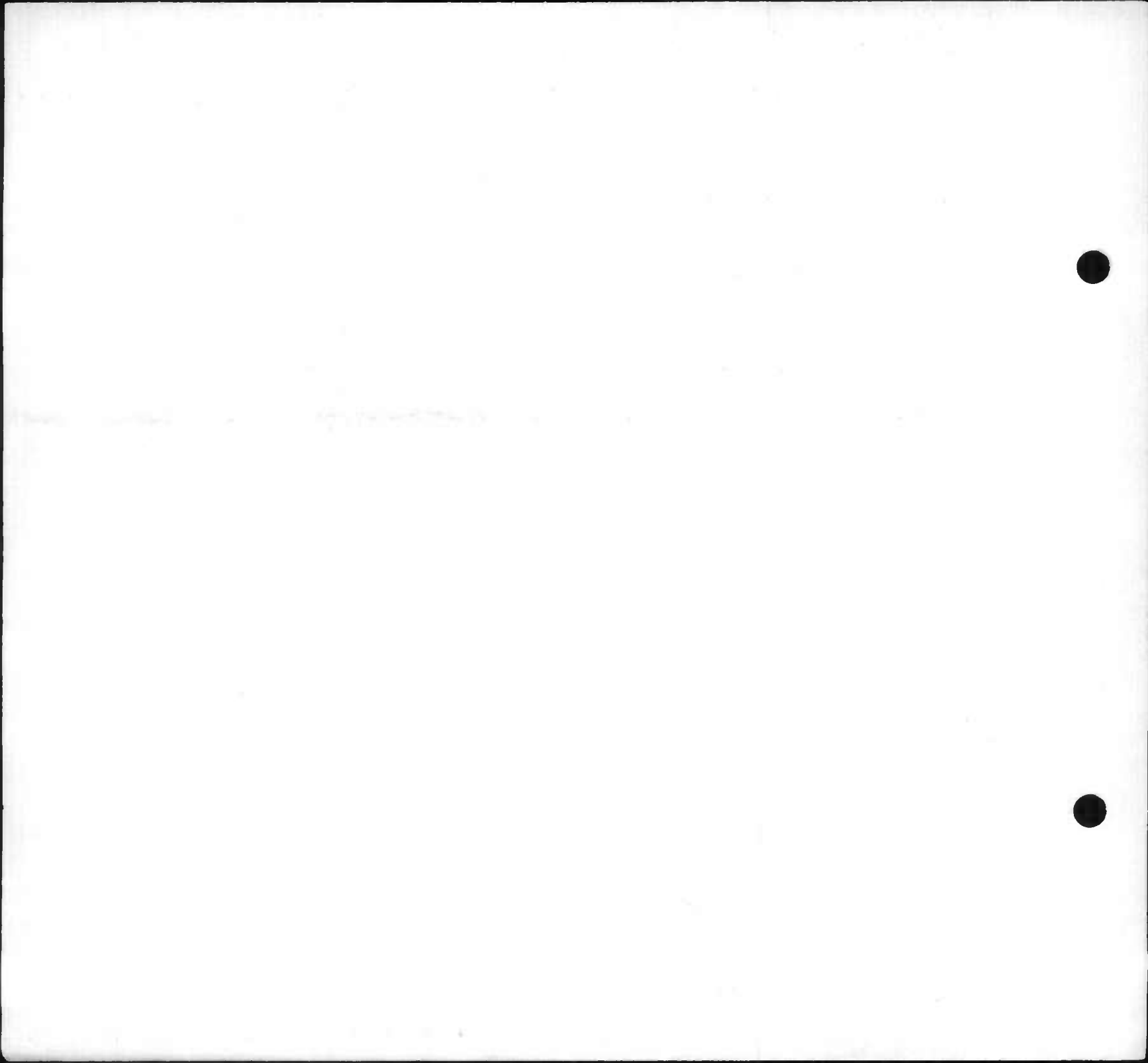
BIRTH NO. <u>J-525</u> <u>71</u> <u>8553</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>8553</u>	
1. NAME OF DECEASED (Type or Print) <u>Johnson, Sarah White</u>			2. DATE AND HOUR OF DEATH <u>September 11, 1971</u> <u>2:50 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1537</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2720 N. Longwood St.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1928</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cytotechnologist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Dr. James A. White Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Mary Sophia Logan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-48-7335</u>		17. INFORMANT <u>Rudolph P. Johnson</u> ADDRESS <u>2720 Longwood St.</u>	
18. <u>4-10-71</u> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Acute CARDIAC FAILURE</u> <u>SEPTIC SHOCK</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9/6/71</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> <u>19</u> <u>71</u> to <u>9-11</u> <u>19</u> <u>71</u> that (I) (we) last saw the deceased alive on <u>9-11</u> <u>19</u> <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gilbert L. Banfield MD</u>			23B. DATE SIGNED <u>9/11/71</u>		23C. ADDRESS <u>722 N. Fulton Ave</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>9-17-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>
24D. LOCATION <u>Baltimore Co. Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		
25B. NAME OF REGISTRAR <u>Rudolph P. Johnson</u>			25C. FUNERAL DIRECTOR <u>1537</u>		
ADDRESS <u>FUNERAL HOME 3035 W. NORTH AVE.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

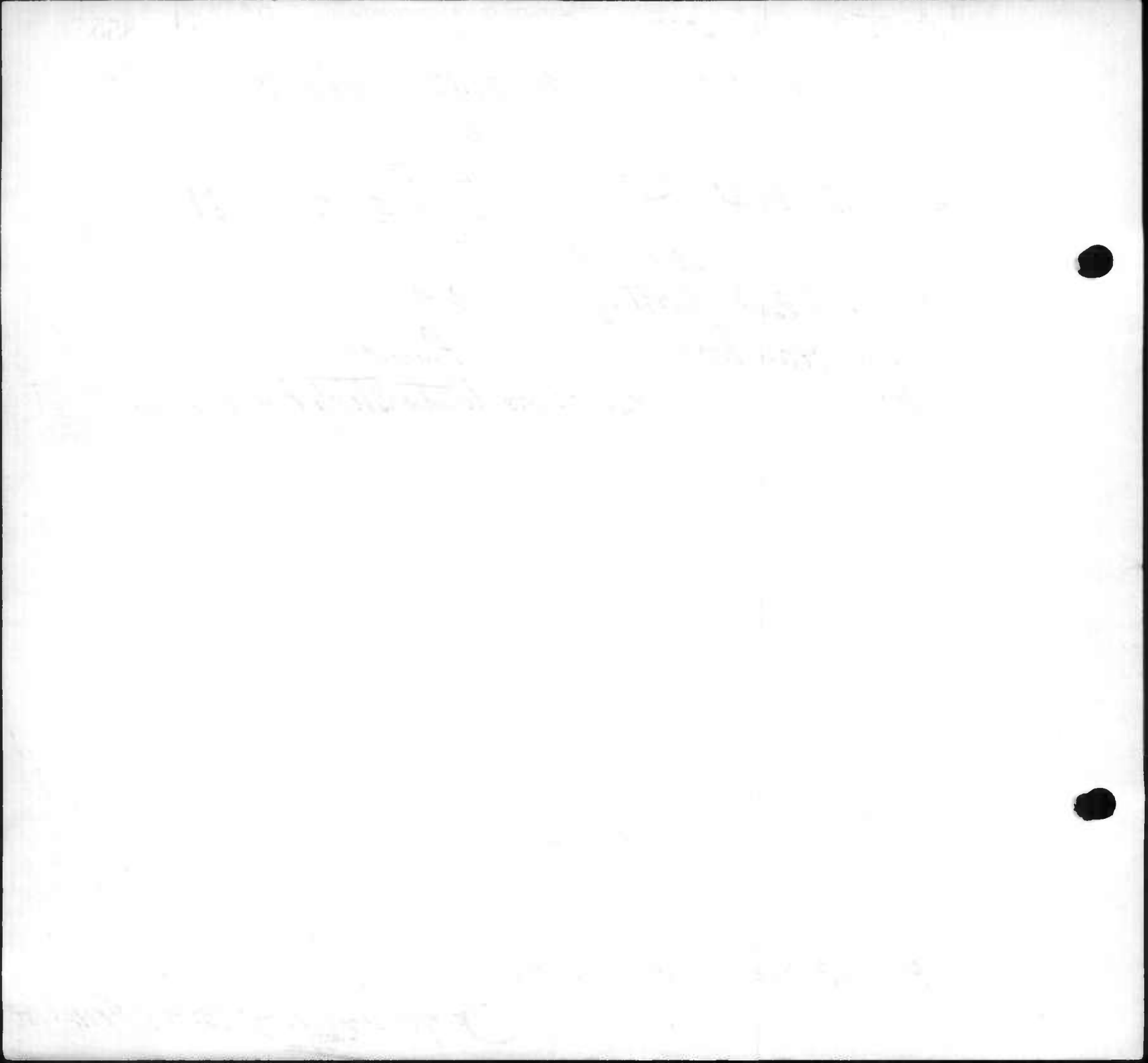
P-630 71 8554		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8554	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>PROUT, VERNON E.</i>		2. DATE AND HOUR OF DEATH <i>Sept. 10, 1971 6:37 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2710</i>		C. CITY OR TOWN <i>Baltimore #21212</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>NORTH CHARLES GENERAL HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>5103 KENILWORTH AVE.</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/19/11</i>	9. AGE (In years last birthday) <i>59 YRS.</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Alex Brown & Sons</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>Walter Prout</i>		14. MOTHER'S MAIDEN NAME <i>Stella Lee</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-01-5394</i>		17. INFORMANT <i>Magery Prout, 5103 Kenilworth Avenue</i>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary edema</i>		<i>1 1/2 hours</i>	
		(B) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>years</i>	
		(C) <i>congestive heart failure</i>		<i>5 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>5</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Verna Sathirakul M.D.</i>		23B. DATE SIGNED <i>9-10-71</i>		23C. PHYSICIAN'S NAME (Type) <i>VEENA SATHIRAKUL M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-15-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>MUTTER FUNERAL HOME 3035 W. NORTH AVE.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. STATE <i>Maryland</i>		24F. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

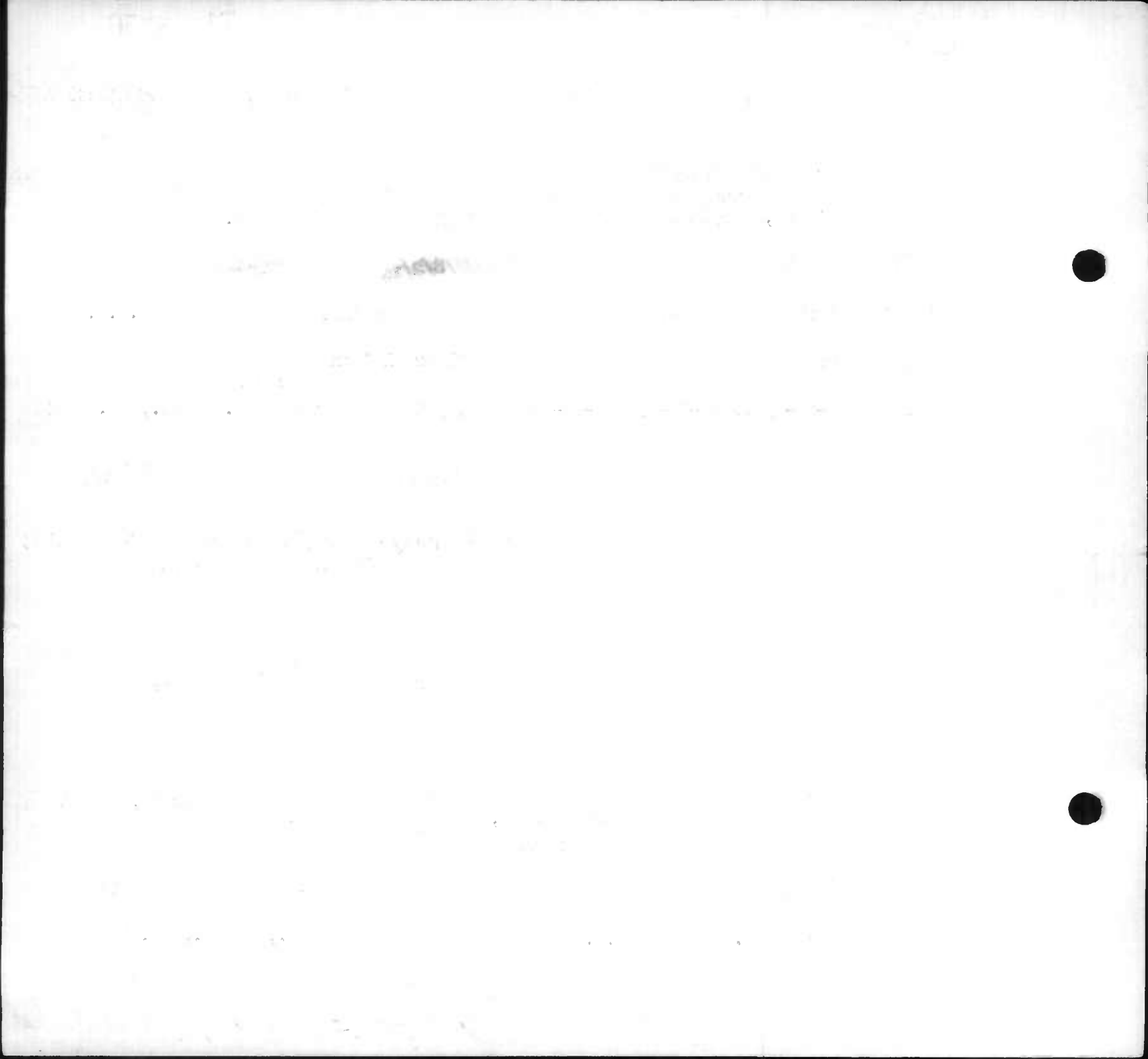
BIRTH NO. 14-252 71 8555		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 71 8555	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William C. Hawkins		2. DATE AND HOUR OF DEATH 9/9/71 3P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 908		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 503 E. 21st St		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 503 E. 21st St			
5. SEX M.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 25/80	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Wm. Hawkins		14. MOTHER'S MAIDEN NAME Emma	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-051423		17. INFORMANT Anita Stamps ADDRESS 503 E. 21st St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO ASHD (B) DUE TO Arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1963 to Sept. 1971 , that (I) (we) last saw the deceased alive on August 28, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jesse T. Holmes		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/10/71	
23C. PHYSICIAN'S NAME (Type) Jesse T. Holmes		23D. ADDRESS M.D. 508 E North Ave. Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) A. D. County Md					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Baker, M.D.		25C. FUNERAL DIRECTOR Joseph Brooks ADDRESS 1304 N. Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650 71 8556		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 8556 REG. NO.	
1. NAME OF DECEASED (Type or Print) GRAHAM, Lawrence Charles			2. DATE AND HOUR OF DEATH September 11, 1971 10:10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1952 Patterson Park Ave.		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/15	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Lucas Brothers		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Lawrence Graham			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Wilmer Allison			15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) Yes 11-18-43 to 10-27-45		
16. SOCIAL SECURITY NO. 213-12-4255		17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd. Balto., Md. 21218			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Aspiration DUE TO, OR AS A CONSEQUENCE OF: (B) Ca. of Esophagus, metastatic DUE TO, OR AS A CONSEQUENCE OF: To Numerous viscera. (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <3 hrs 6 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from August 27 19 71 to September 11 , 19 71 that (X) (we) last saw the deceased alive on September 11 , 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) not view the body after death.					
23A. SIGNATURE Richard A. Tomosula M.D.			23B. DATE SIGNED 9/12/71		23C. PHYSICIAN'S NAME (Type) Richard A. Tomosula M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/15/71		24C. NAME of CEMETERY or CREMATORY Garden of Eternal Hope
24D. LOCATION (City, town, or county) (State) Finksburg, Md			25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		
25B. NAME OF REGISTRAR John E. Taylor, M.D.			25C. FUNERAL DIRECTOR Joseph B. Locks		
25D. ADDRESS 304 R. Central					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 8557

BIRTH NO.

71 8557

1. NAME OF DECEASED

(Type or Print)

DRUMMOND LEWIS

2. DATE AND HOUR OF DEATH

9/9/71

8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

MD

ANNE

ARUNDEL

5200

C. CITY OR TOWN

Millersville

D. INSIDE CITY LIMITS?

YES

NO

E. STREET AND NUMBER

236A Obrecht Road

5. SEX

M

6. RACE

Caucasian

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

9/16/14

9. AGE (in years last birthday)

56

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

(SELF EMP.) ret.

10B. KIND OF BUSINESS OR INDUSTRY

SOUTHERN SPRING

SERVICE

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Upshur Lewis

14. MOTHER'S MAIDEN NAME

Sarah Core

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

082 16 6663

17. INFORMANT

Mrs. Mildred M. Lewis (wife)

ADDRESS

Hospital Chart Same As #4

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Gastrointestinal Hemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hepatic Failure

(C)

Acute Myelomonocytic Leukemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work

Not While At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/23 19 71 to 9/9 19 71 that (I) (we) last saw the deceased alive on 9/9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MARK H. KASOWITZ MD

DEGREE

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

9/9/71

23C. PHYSICIAN'S NAME (Type)

MARK H. KASOWITZ

DEGREE

23D. ADDRESS

UNIV. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Sep't. 13/71

24C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

24D. LOCATION

Brooklyn, RFD, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1971

25B. NAME OF REGISTRAR

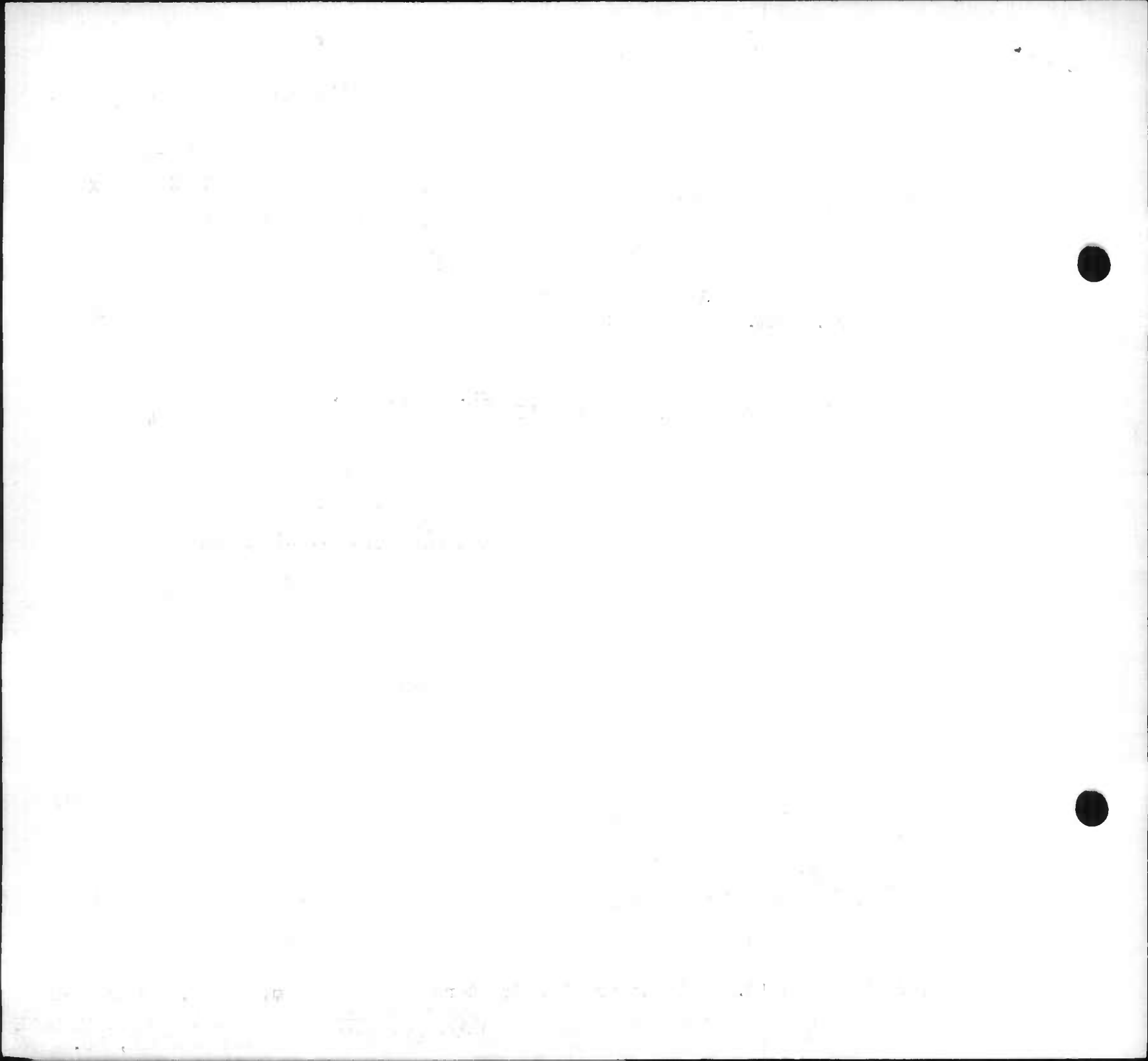
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

W. J. Singleton

ADDRESS

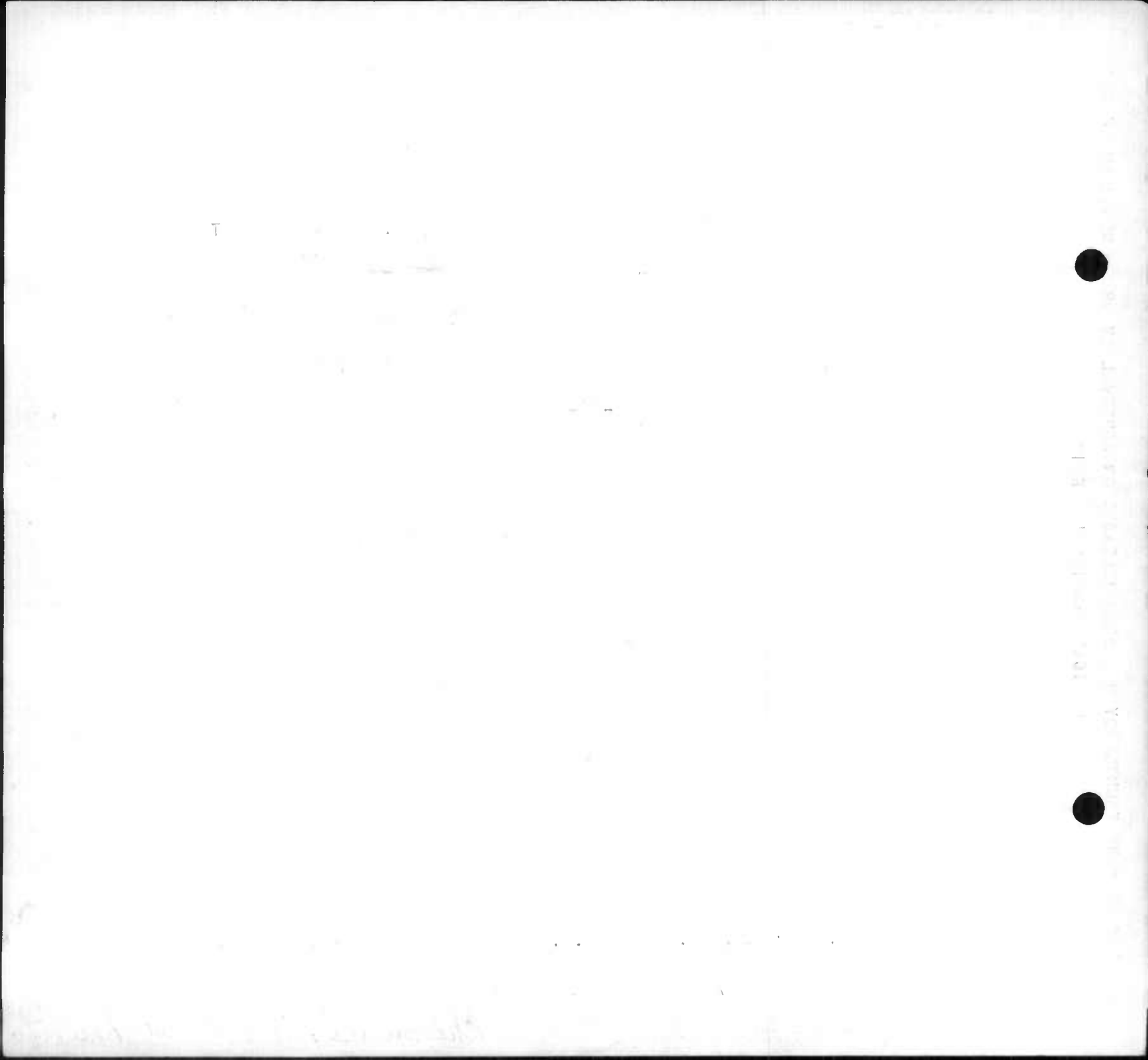
SINGLETON FUNERAL HOME
GLEN BURNIE, MD.



BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY PETTIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 6 71 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1421 Argyle Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 6 1971 8:10 a M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1402	
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Aug. 1893		10. AGE (In years lost birth) 78		E. STREET AND NUMBER 1421 Argyle Ave.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Mildred Anderson	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Russell S. Fisher</u> M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/6/81					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem	
24D. LOCATION (City, town, or county) (State) A.A. Co Md		25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Patricia E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Fisher Funeral Home		25D. ADDRESS 1016-13 N. Arlington			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8559	
F534 1					
7-534/1 8559					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary Fauntleroy			
2. DATE AND HOUR OF DEATH Sept 4, 1971 112 Noon M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN Baltimore E. STREET AND NUMBER 2235 E. PRESTON STREET		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-97	9. AGE (in years last birthday) 73	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Northumberland Co. Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WALTER RICE		14. MOTHER'S MAIDEN NAME ROSIE GASKINS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-16-3090		17. INFORMANT Genevieve Johnson-2235 E. Preston	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E880X Fracture Cervical Spine & Spinal Cord Injury		CAUSE OF DEATH IMMEDIATE CAUSE C-C Flexion Extension Fall down stairs on 9/1/71 ASCD, FIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Card Injury	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		21. ASACU	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2235 E. Preston Street	
21D. TIME OF INJURY (APPROX.) 9 1 21 8:30 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. fell down basement steps	
22. I certify that (I) (this hospital) attended the deceased from Sept 1 1971 to Sept 4 1971 that (I) (we) last saw the deceased alive on Sept 4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Varnell, Jr. M.D.		23B. DATE SIGNED 9/4/71		23C. PHYSICIAN'S NAME (Type) JAMES W. VARNELL, JR. M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9-8-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Morris Dett F.H. 1701-1440	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8560

BIRTH NO. 71 8560

1. NAME OF DECEASED
(Type or Print)

ANNIE NORMAN (SAVAGE)

2. DATE AND HOUR OF DEATH

9-10-71 10:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Ashburton Nursing Home
3520 N. Hiltow Rd
Baltimore, Md 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD. B. COUNTY 1703

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

616 W. Lafayette Ave

5. SEX

F

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-21-06

9. AGE (In years lost birthday)

65

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Edenton, N. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

unkn.

14. MOTHER'S MAIDEN NAME

unkn.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-36-0667

17. INFORMANT

Herman Cooper, 4014 Bateman Ave., 21216

ADDRESS

18.

412.3 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Arteriosclerotic heart disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

unknown

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cerebral arteriosclerosis

unknown

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug. 30, 1971 to Sept. 10, 1971 that (I) (we) last saw the deceased alive on Sept. 9, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Abraham B. Hurwitz MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Sept. 10, 1971

23C. PHYSICIAN'S NAME (Type)

ABRAHAM B. HURWITZ MD

23D. ADDRESS

7501 Liberty Road Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/13/71

24C. NAME OF CEMETERY OR CREMATORY

Edenton Cem.

24D. LOCATION

Edenton, N. C.

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1971

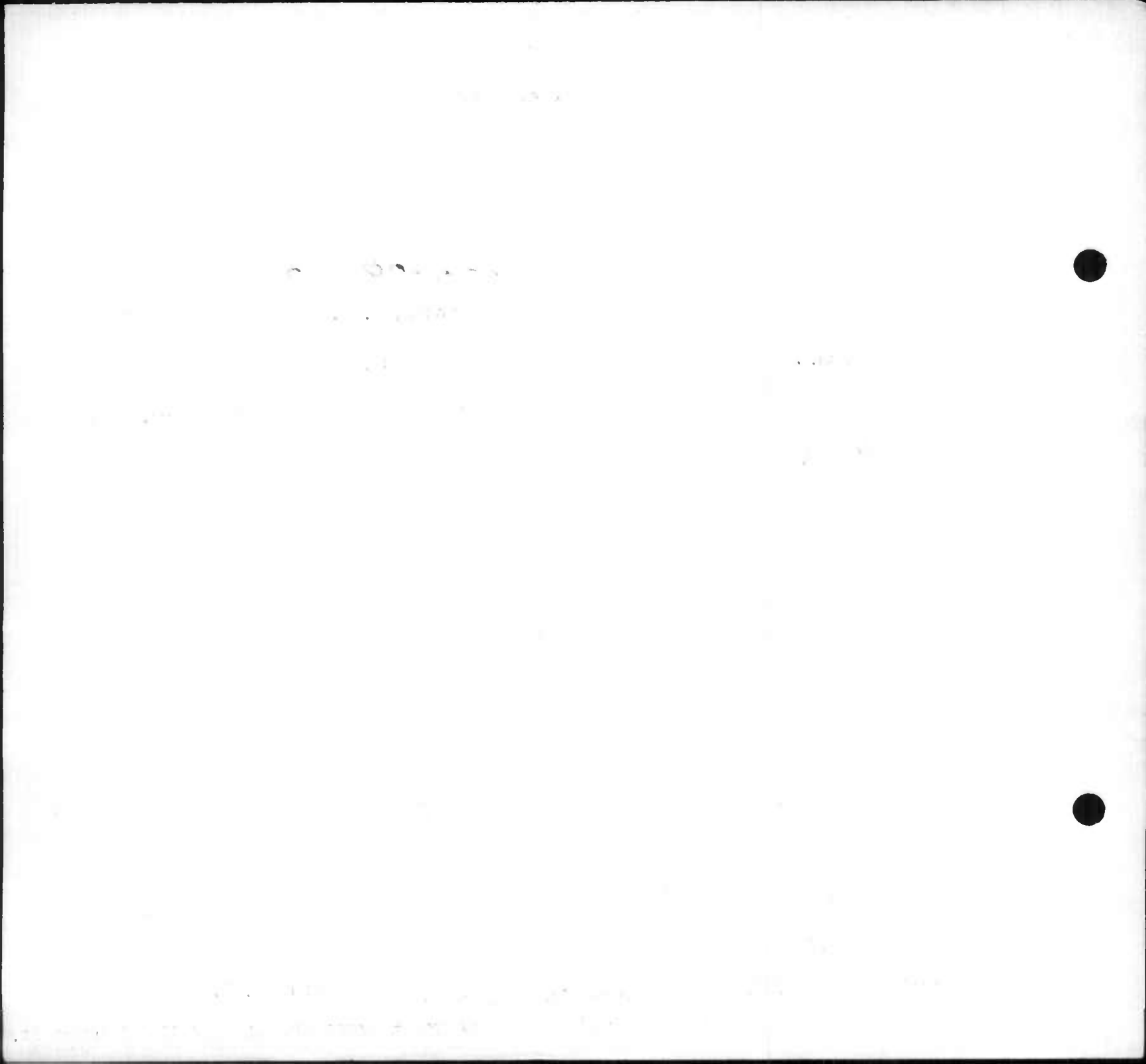
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

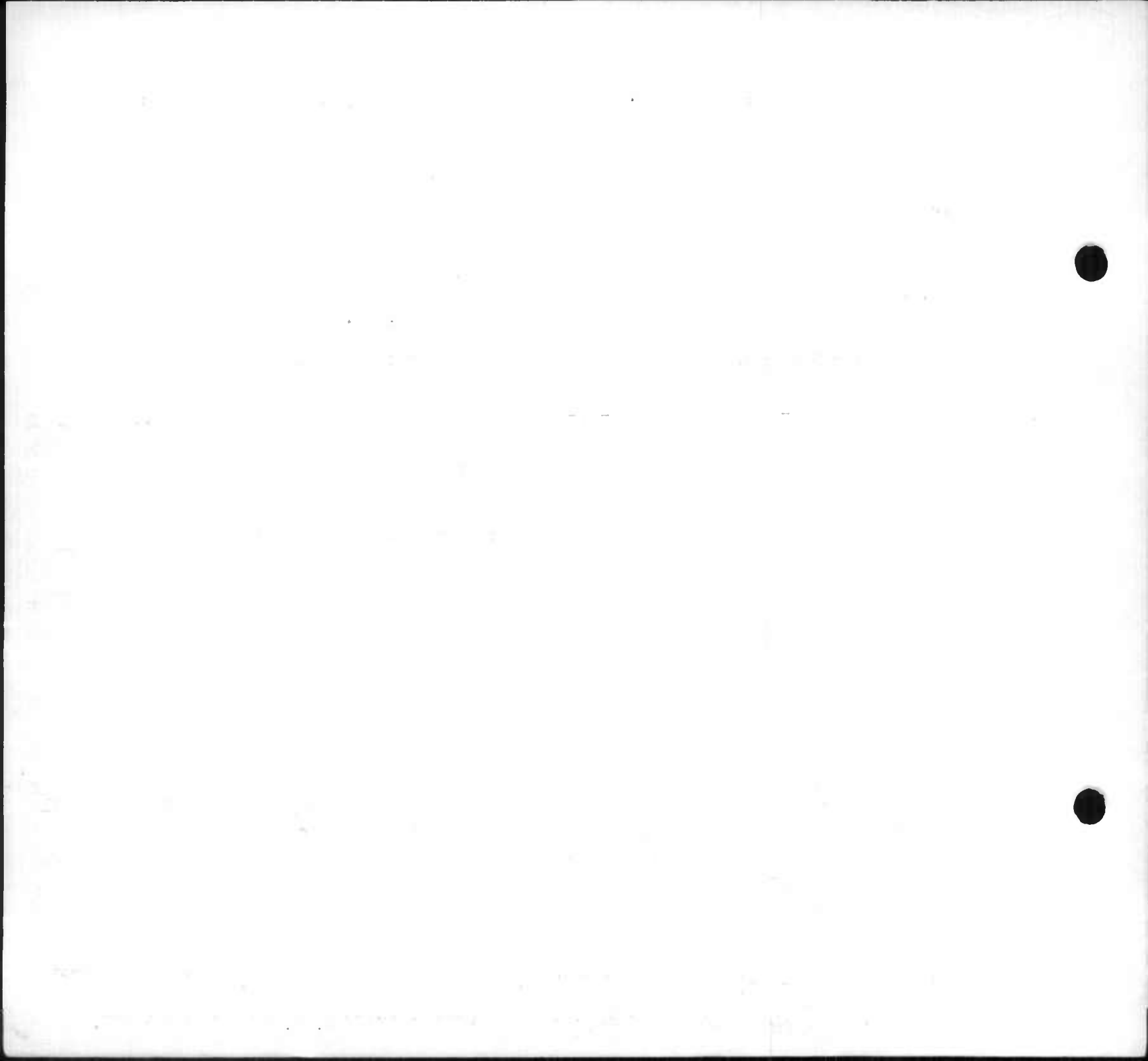
MORTON & DYETT FUNERAL HOME 1701 Laurens St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8561	
BIRTH NO. 71 8561				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FERGUSON, CHARLES H.				2. DATE AND HOUR OF DEATH 9/9/71 5:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1603 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 541 N Mount Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/04	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY roofing		11. BIRTHPLACE (State or foreign country) Lee Hall, Va.	
13. FATHER'S NAME Jerry Ferguson			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942 - 1945			16. SOCIAL SECURITY NO. 217-07-2548		17. INFORMANT VA Hospital Records 3900 Loch Raven Boulevard Balto., Md 21218
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Carcinoma of esophagus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Possible cerebral vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 10th 19 71 to September 8th 19 71 that (I) (we) last saw the deceased alive on September 8th 19 71 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MR. P. H. M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-14-71		24C. NAME OF CEMETERY or CREMATORY MT CALVERY CM.	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F. H. 1701 LAURENS STS.	



1
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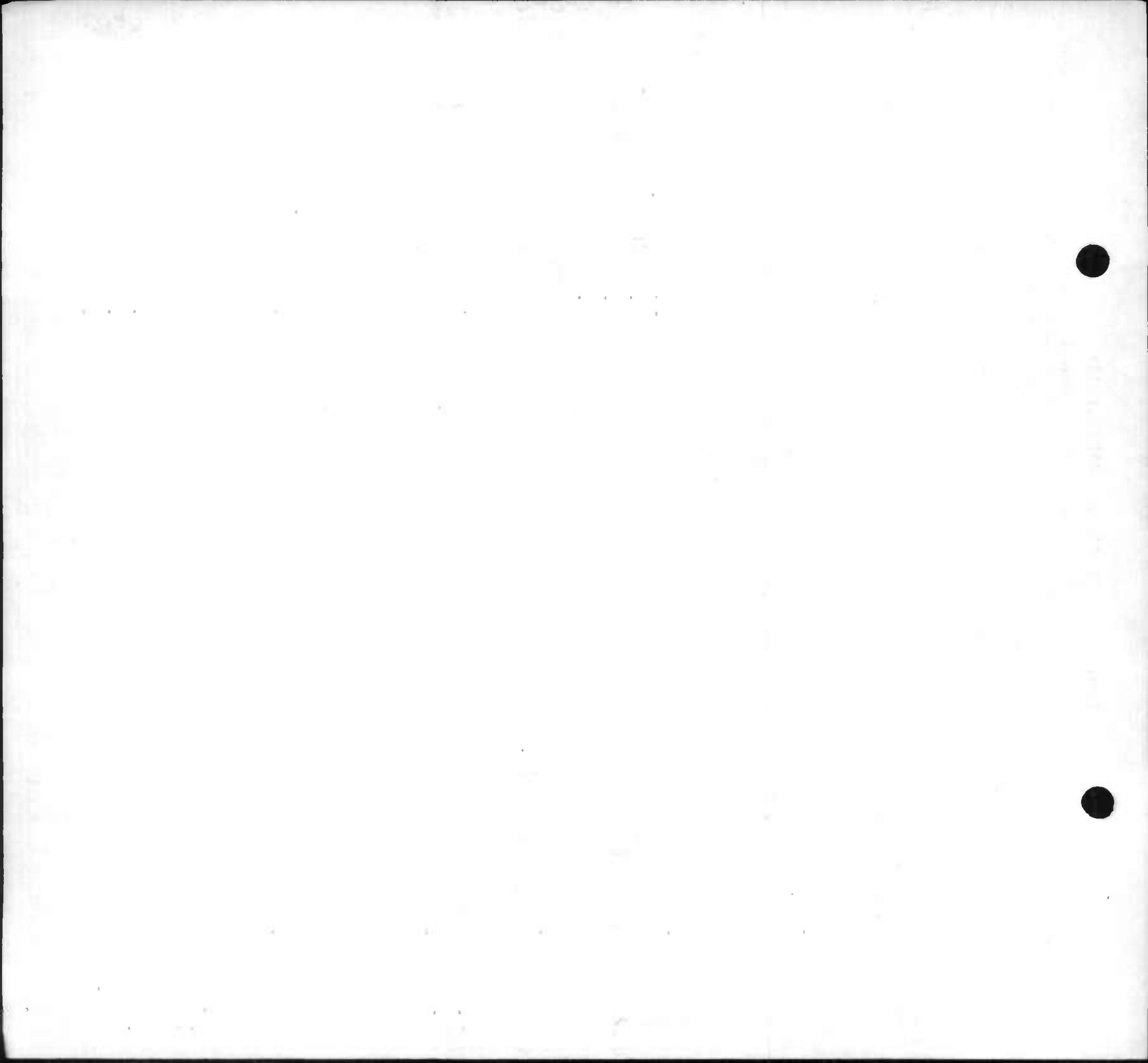
BALTIMORE CITY HEALTH DEPARTMENT

71 8562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 8562	
1. NAME OF DECEASED (Type or Print) James Townes				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 11, 1971 6:55 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour September 11, 1971 6:55 AM	
6. SEX Male				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Colored				C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug, 20, 1950				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 21				E. STREET AND NUMBER 2600 Round Rd.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Mahatt				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator	
15. MOTHER'S MAIDEN NAME Darphelia Townes				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
17. SOCIAL SECURITY NO. 219-52-6809				18. INFORMANT ADDRESS Mozelle Clark 1113 Edmondson Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9-15-71				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? kitchen of Apt. B-1, 2600 Round Rd.	
22D. TIME OF INJURY (APPROX.) 9, 11, 1971 2:25 AM				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? stabbed during argument				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED Sept. 11, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-15-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971				25B. NAME OF REGISTRAR Robert E. Gabe, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens St.					

FUNERAL DIRECTOR: IMPORTANT

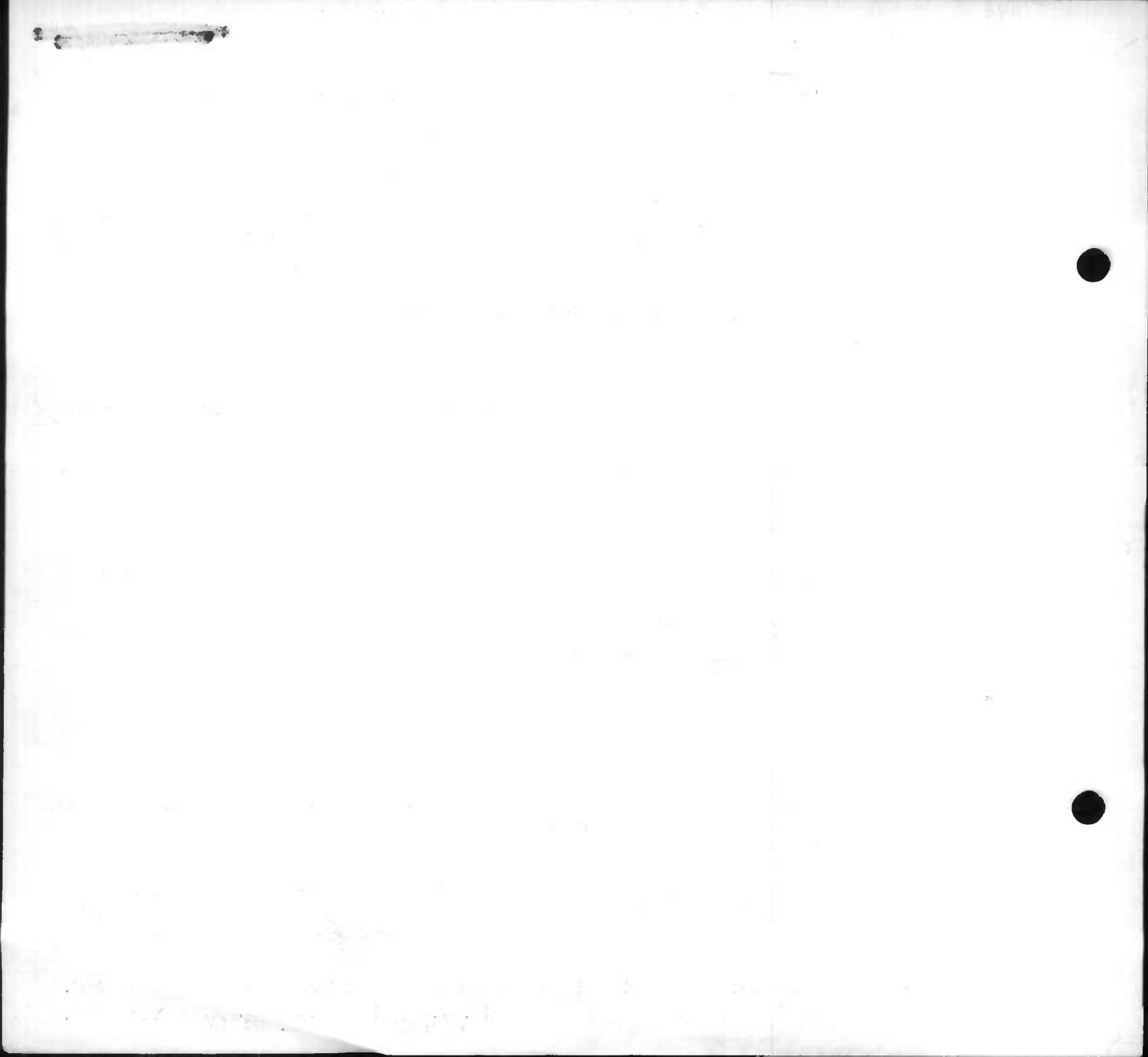
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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8563	
S-315 71 8563 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William H. Stevenson		September 10, 1971		4 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 324 Radnor Ave.		A. STATE Maryland		B. COUNTY 2711	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/7/1910		9. AGE (In years last birthday) 61		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mechanical Engineer		U.S.F.G. Gen. Services Admin. Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stevenson		14. MOTHER'S MAIDEN NAME Lena Peort			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lydia J. Stevenson (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH HEPATIC CARCINOMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probably Primary (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 mos	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-8-71 to 9-10-71 that (I) (we) last saw the deceased alive on 9-9-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. P. Benson, Jr. M.D.				23B. DATE SIGNED 9-13-71	
23C. PHYSICIAN'S NAME (Type) Dr. William P. Benson, Jr.				23D. ADDRESS 3502 N. Calvert St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY OR CREMATORY Baltimore	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 19 1971		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. DATE REC'D BY HEALTH DEPT. SEP 19 1971		24H. NAME OF REGISTRAR Robert E. Taylor, M.D.		24I. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

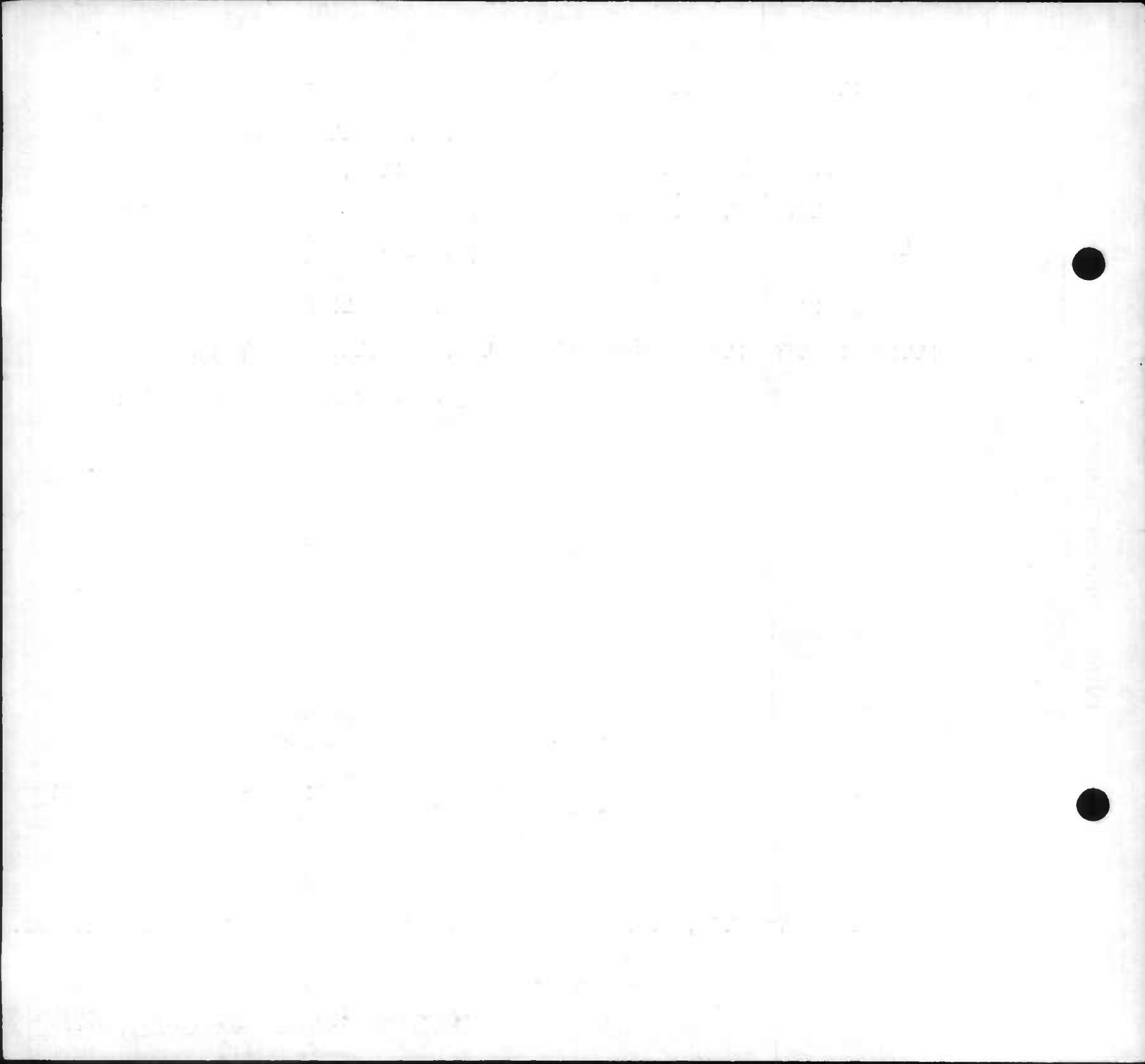
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8564</u>	
P-320 71 8564				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES POTTS</u>		2. DATE AND HOUR OF DEATH <u>5:07 AM 9/12/71</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>5 CHURCH HOME & HOSPITAL</u> <u>100 N. Broadway</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1201</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9/27/1899</u>		9. AGE (in years last birthday) <u>71</u>		10. IF Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GENERAL MOTORS</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Potts</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE WHEATLEY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 01 3583</u>		17. INFORMANT <u>Mrs Helen M. Potts</u> ADDRESS <u>(Same)</u>	
18. I <u>1</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <u>Post left pneumonia state due</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>to Ca left lung with metastasis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Colchic therapy → anemia, Thrombocytopenia</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> 19 <u>71</u> to <u>9/12</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/11</u> pm 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nabih Jager</u>		23B. DATE SIGNED <u>9/12/71</u>		23C. PHYSICIAN'S NAME (Type) <u>E. BORHANI ALAR</u>	
23D. ADDRESS <u>Staff - Church Home & Hosp.</u>		23E. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		23F. FUNERAL DIRECTOR <u>Howe Jenkins Sons Co.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-15-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville</u>		24E. ADDRESS <u>4905 York Rd.</u>		24F. CITY, TOWN, OR COUNTY <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Howe Jenkins Sons Co.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8565</u>	
BIRTH NO. <u>W-425 71 8565</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILSON WILLIE (NMN)</u>			2. DATE AND HOUR OF DEATH <u>9-8-71 1:20 P</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSP. 900 CATON AVE. BALTIMORE, MD. 21229</u>			A. STATE <u>MD.</u> B. COUNTY <u>CARROLL COUNTY</u>		
			C. CITY OR TOWN <u>SYKESVILLE,</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>RT 3 BOX 469 21784</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-23</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET MECHANIC</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>WILLIE PINKLEY WILSON DECEASED</u>		
14. MOTHER'S MAIDEN NAME <u>LUCINDA WILLIAMS WILSON</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>YES WW 2</u>		
16. SOCIAL SECURITY NO. <u>241300240</u>			17. INFORMANT <u>ST AGNES HOSP 900 CATON AVE.</u>		
18. <u>470.9 I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular shock</u>			<u>24 hours</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recent M.I.</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		
			(C) <u>ASCVD</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9-11-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical examination)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> 19 <u>71</u> to <u>9-8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-8-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paul Westphalen M.D.</u>				23B. DATE SIGNED <u>9/8/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>PAUL WESTPHALEN, M.D.</u>				23D. ADDRESS <u>ST AGNES HOSP 900 CATON AVE. BALT. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-11-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial Park Sykesville Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Sykesville Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Harry W. Knight Sykesville, Md.</u>			



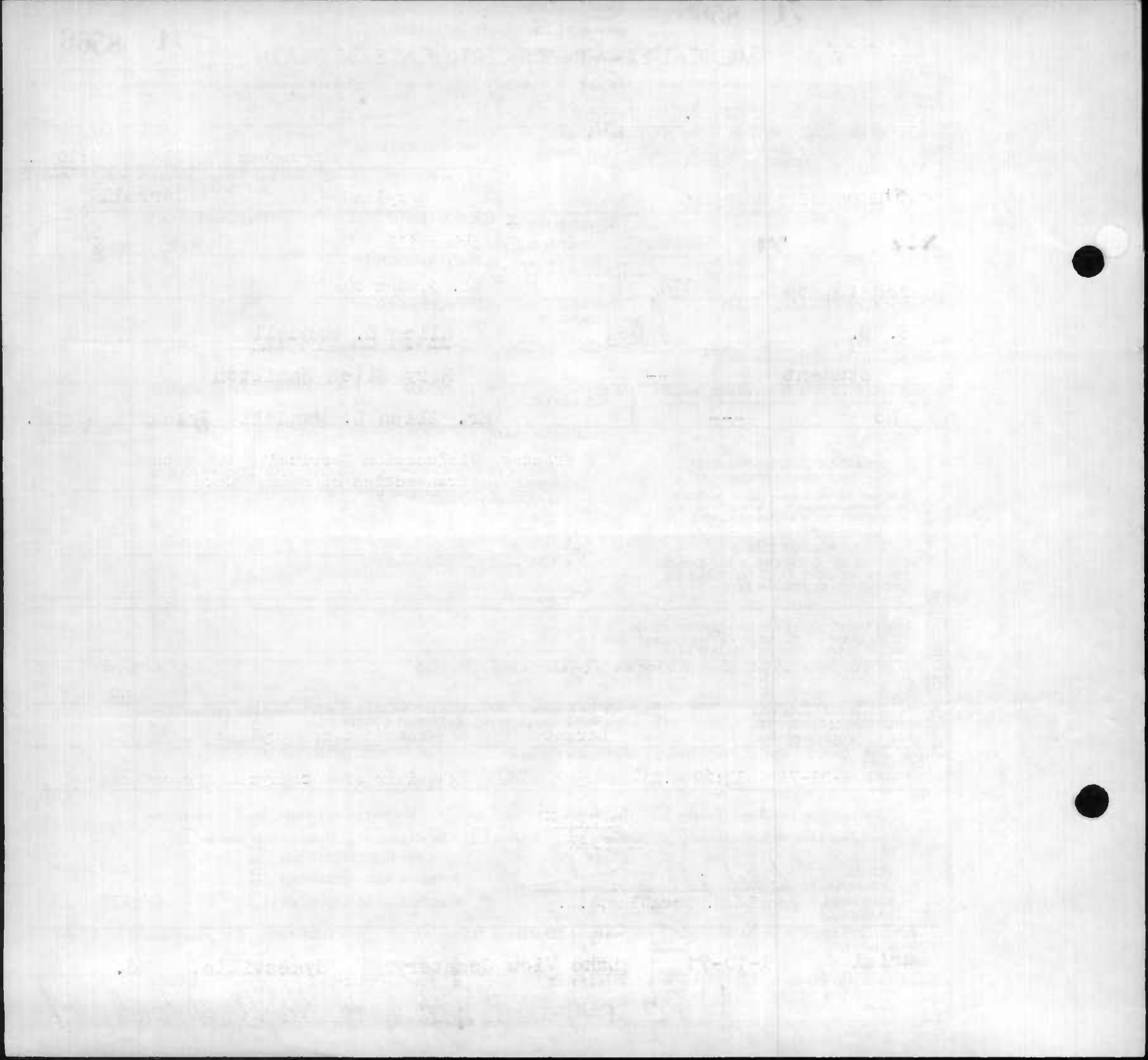
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BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

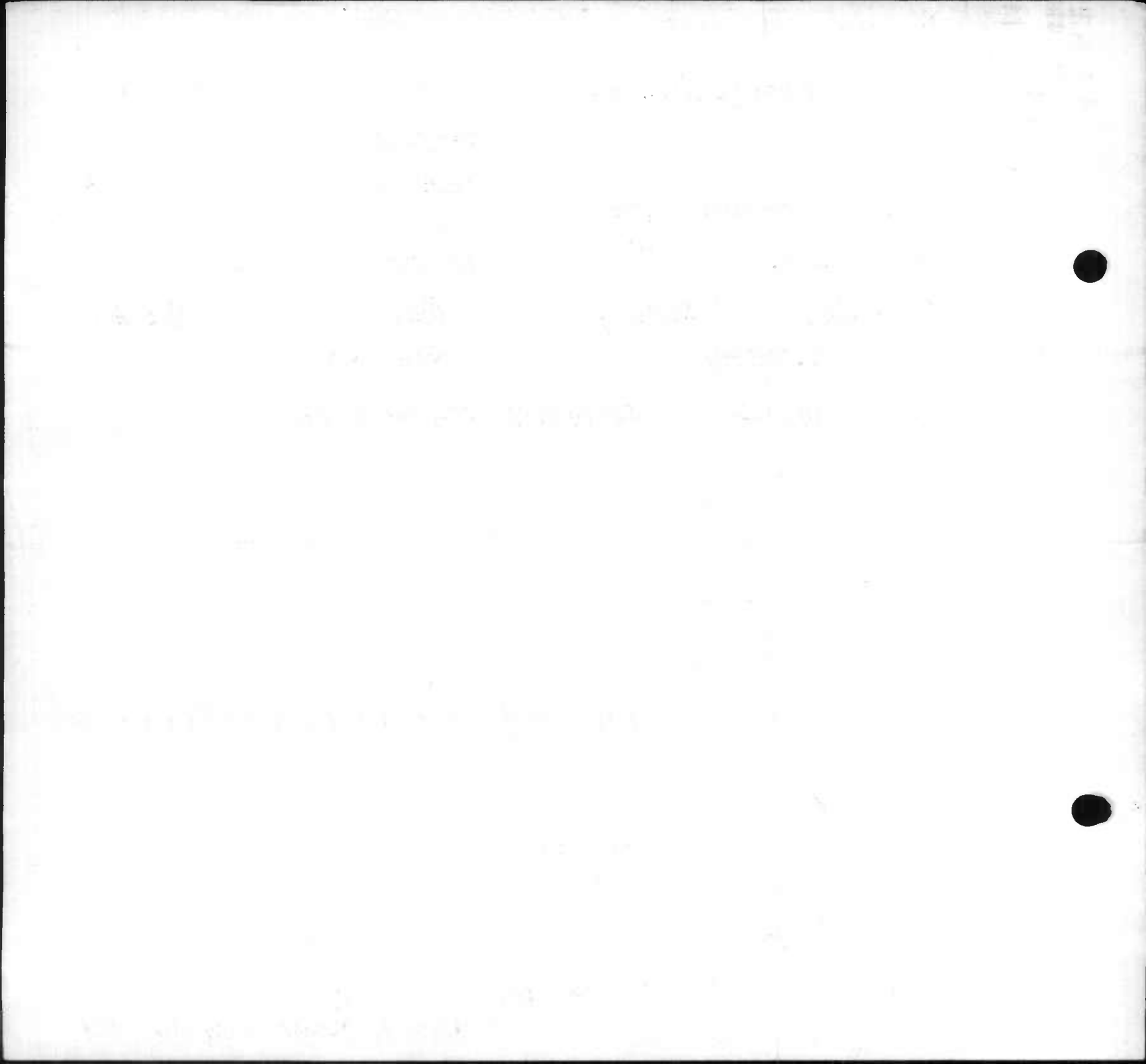
BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALLEN M. WANDELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 8, 1971 4:10 A.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Carroll 5600	
9. DATE OF BIRTH March 16, 54		10. AGE (In years last birthday) 17 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) S. D.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY --	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. ---	
13. FATHER'S NAME Allen L. Wandell		15. MOTHER'S MAIDEN NAME Mary Ellen Hamilton	
18. INFORMANT Mr. Allen L. Wandell		ADDRESS Sykesville, Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fracture Dislocation Cervical Spine with Transection of Spinal Cord (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 8-31-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Westminster, Maryland 5600		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-31-71 12:20 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver of motorcycle struck tree	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 9/8/71 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-71	
24C. NAME of CEMETERY or CREMATORY Lake View Cemetery		24D. LOCATION (City, town, or county) (State) Sykesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 19 1971		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	
25C. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

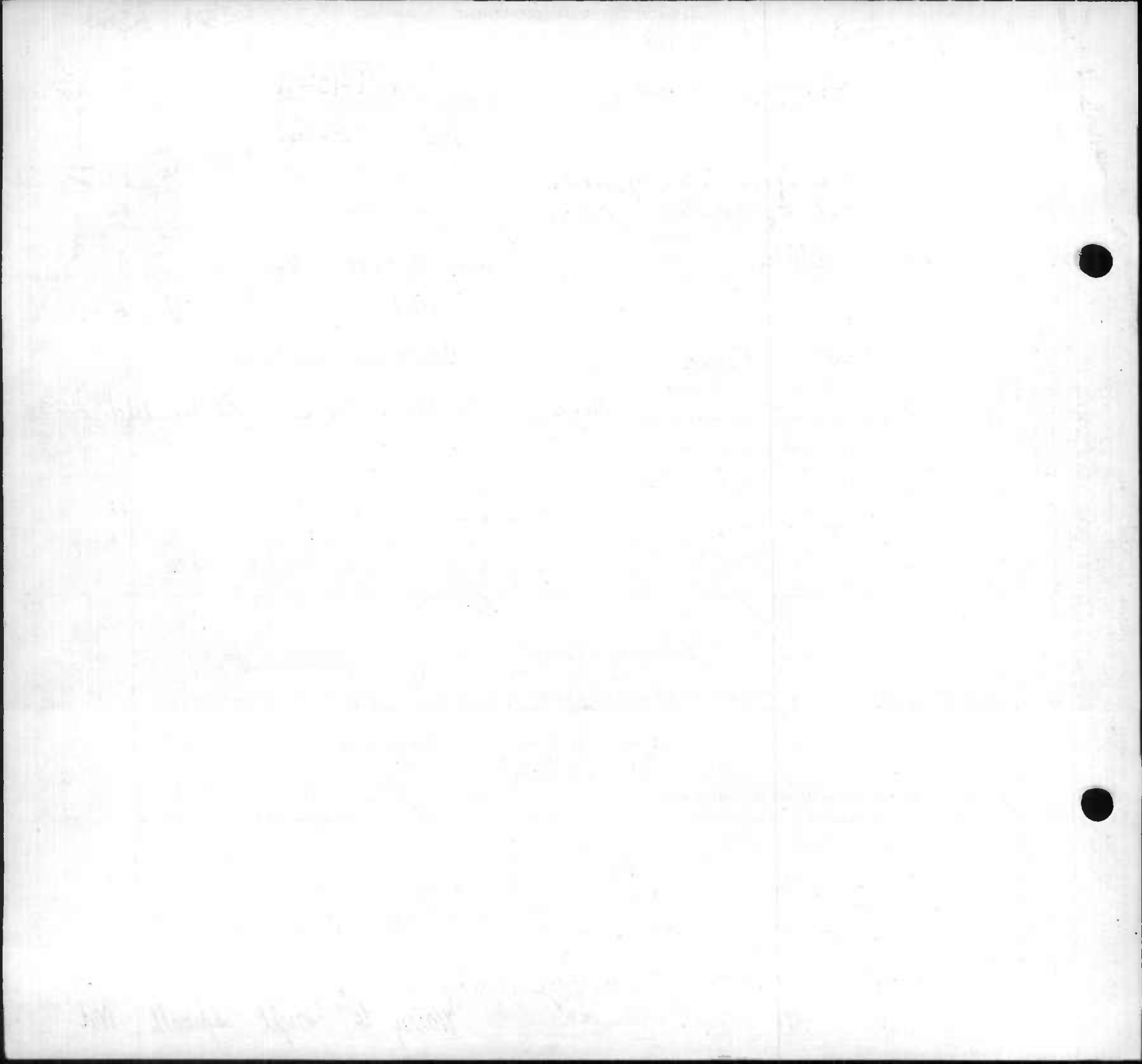
D-620 71 8567		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 8567	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) George E. Dorsey		2. DATE AND HOUR OF DEATH 9-10-71 12:06 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4118 Essex Road			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/04/20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George F. Dorsey		14. MOTHER'S MAIDEN NAME Edith Gill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 220 07 0617		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) BRAIN Tumor (Glioblastoma) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 24 1971 to Sept. 10 1971 that (I) (we) last saw the deceased alive on Sept 9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Horan MD		23B. DATE SIGNED 9-10-71		23C. PHYSICIAN'S NAME (Type) M. HORAN M.D.	
23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-71		24C. NAME OF CEMETERY OR CREMATORY Lake View Cemetery	
24D. LOCATION Sylasville, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 13 1971			
25A. NAME OF REGISTRAR Robert E. Sabel, MD.		25B. NAME OF REGISTRAR Robert E. Sabel, MD.		25C. FUNERAL DIRECTOR Nancy W. Haight	
25D. ADDRESS Sylasville, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

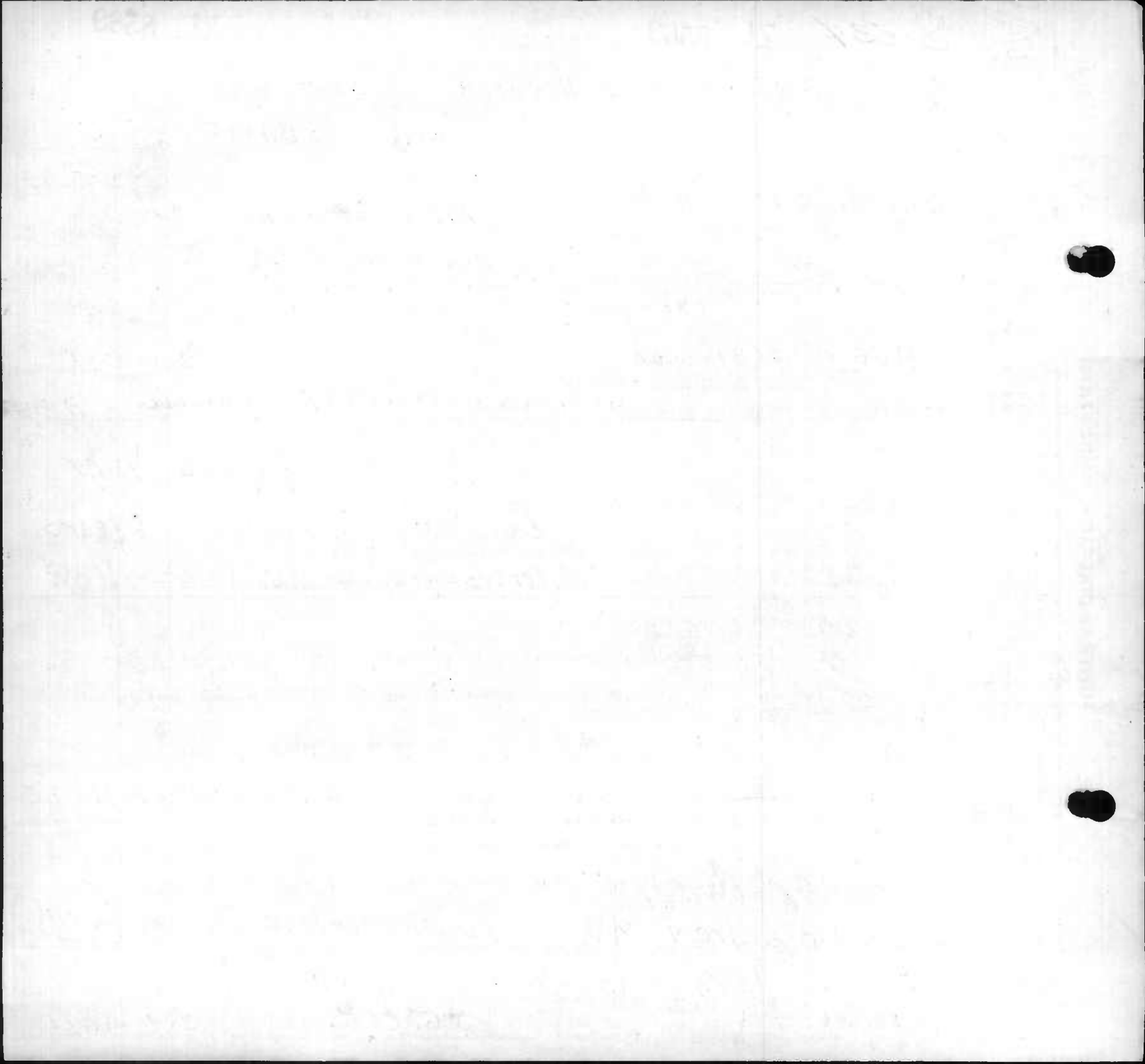
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8568	
7-620 71 8568		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EDWARD FORCE		2. DATE AND HOUR OF DEATH 9-10-71 12 40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Lake Drive Nursing Home 2401 EUTAW PLACE BALTO.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5300	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1899 9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Force		14. MOTHER'S MAIDEN NAME Catherine Getchel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Philip Force ADDRESS BALTO. MD. 21230
18. 4-12-4-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio pulmonary arrest. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease CBS & generalized - widespread Cerebrovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Cerebrovascular disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 8-13-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5 1971 to 9-10 1971 , that (I) (we) last saw the deceased alive on 8-26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature] M.D. DEGREE		23B. DATE SIGNED 9-10-71	
23C. PHYSICIAN'S NAME (Type) M. Anne Wood F. Albuerne DEGREE		23D. ADDRESS 7535 RIDGE PARK (N.W. BURNIE MD) 21061	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-13-71	24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	24D. LOCATION (City, town, or county) (State) Elkridge Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Harry W. Haight ADDRESS Sparksville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

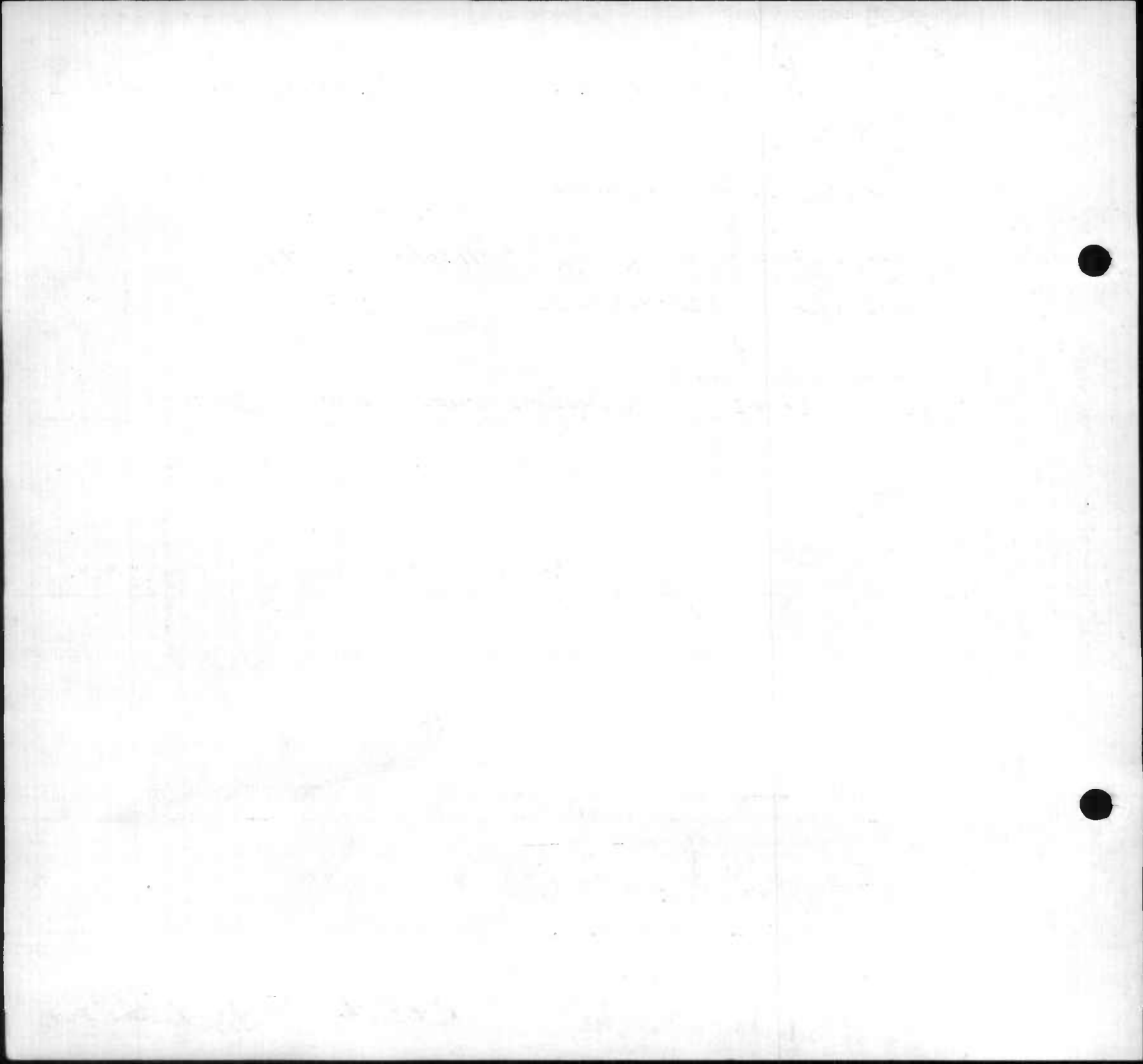
S-534 71 8569		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 8569	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES H. SCHINDLER		2. DATE AND HOUR OF DEATH SEPT. 4, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO 5300		5. CITY OR TOWN EASTBENT	
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 16, 1910	
9. SEX M		10. AGE (In years last birthday) 61		11. BIRTHPLACE (State or foreign country) MD	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HUGO SCHINDLER		14. MOTHER'S MAIDEN NAME SCHEATLE		ADDRESS ABOVE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VNK		16. SOCIAL SECURITY NO. 213-01-2217		17. INFORMANT ELIZABETH SCHINDLER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE HEART FAILURE 1/2 hr. CORONARY THROMBOSIS 6 years. ARTERIOSCLEROTIC HEART DISEASE 6 years.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 19 65 to SEPT 4, 1971, 1971 that (I) (we) last saw the deceased alive on AUGUST 27, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David H. Andrew MD		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) David H. Andrew MD		23D. ADDRESS 2205 Stony Run Lane Baltimore, Md 21210			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/8/71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN	
24D. LOCATION BALTO. MD		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR J.G. COMVELLY	
				ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

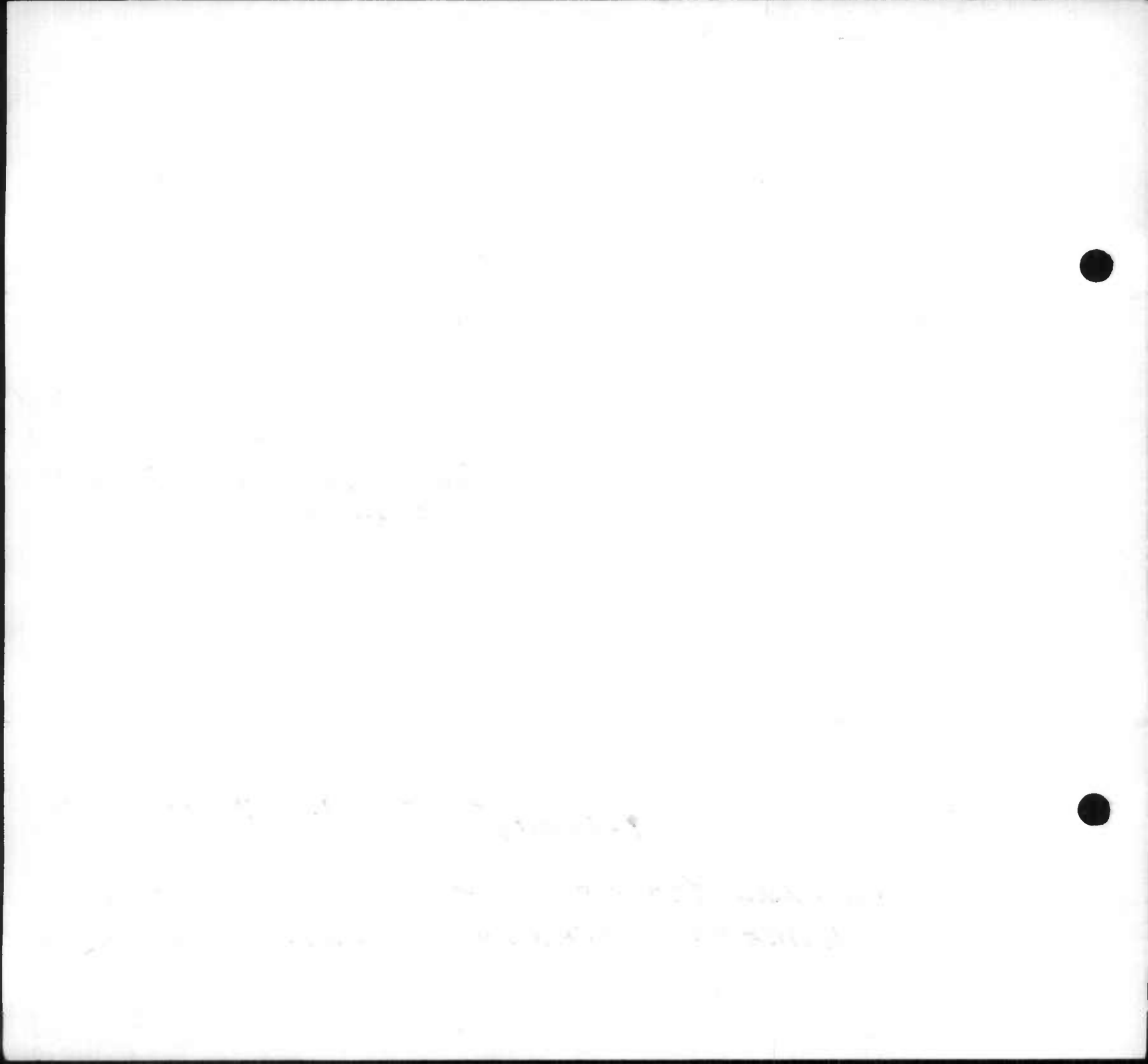
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8570	
BIRTH NO. 71 8570				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ROBERT E. BUTLER		SEPT 10, 1971		6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 ARDLEIGH NURSING HOME			A. STATE MO. B. COUNTY 1348		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3516 POOLE ST.		
5. SEX MALE	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/1900	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORGMAN		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 216-10-1806		17. INFORMANT ADDRESS ETHEL A. HOOVER (SAME)	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardio-vascular disease (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic brain syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 3 yrs. 3 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1970 to September 10, 1971 , that (I) (we) last saw the deceased alive on August 29, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor				23B. DATE SIGNED Sept. 10, 1971	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.				23D. ADDRESS 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/13/71		24C. NAME OF CEMETERY OR CREMATORY EUGENECREE MEM.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 18 1971			
25B. NAME OF REGISTRAR Robert E. Saylor, M.D.		25C. FUNERAL DIRECTOR Robert E. Saylor		25D. ADDRESS 3617 Chestnut Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

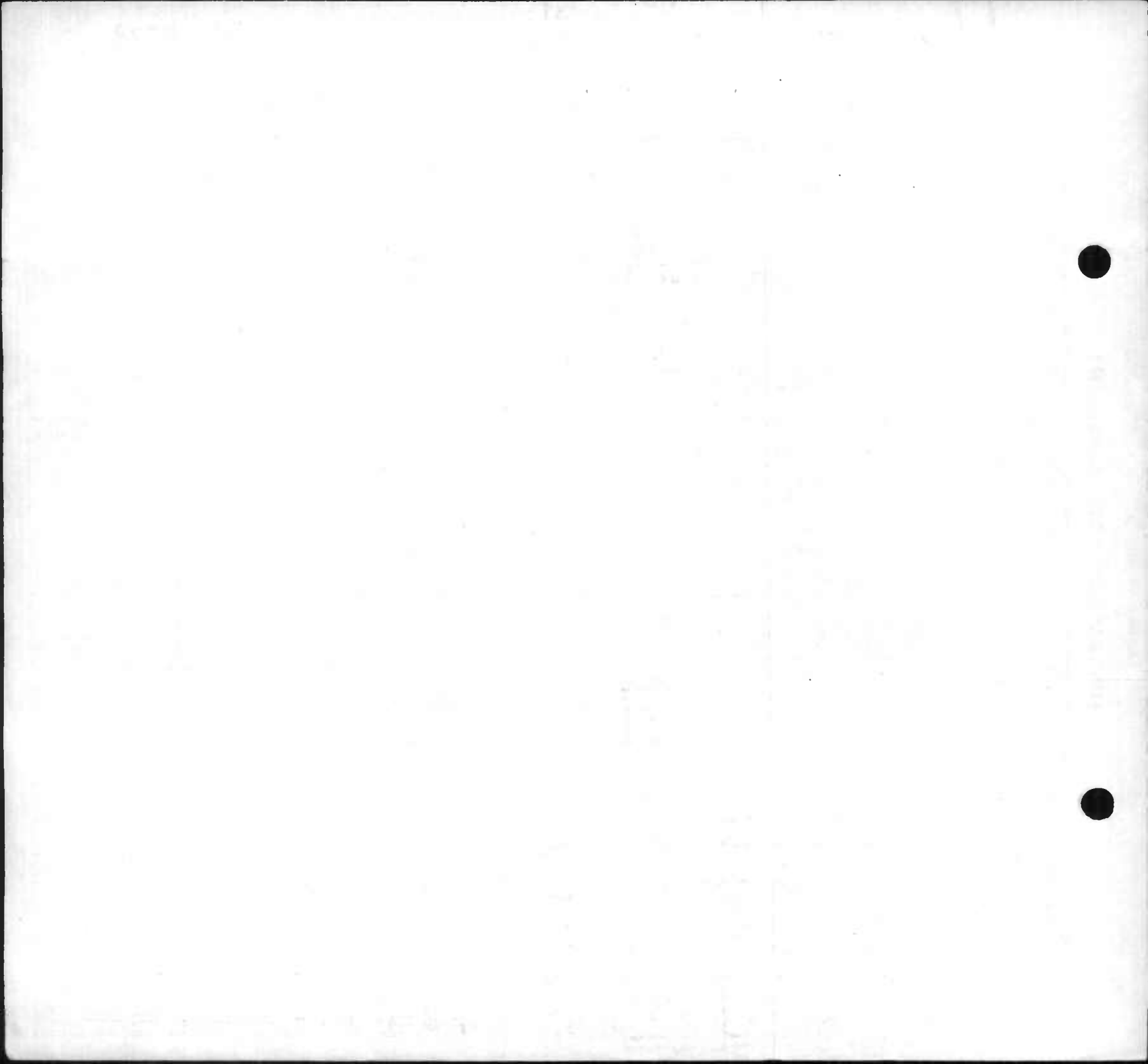
S-152 71 8571		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8571	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mary E. Spencer		9/9/71		4 45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		2553	
2057 Grinnolds Ave		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
2057 Grinnolds Ave					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F.	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/3/1900	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Steamstress		Clothing Co.		W. Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jerry Evans		Elizabeth ?		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				Mr. George H. Spencer	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		one year	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-15-1971 to 9-9-1971 that (I) (we) lost saw the deceased alive on 9-8-1971 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nureddin Erk. M.D.				4-10-1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
NUREDDIN ERK, M.D.				2436 Washington Blvd, Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/13/71		Green Haven Cem.	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Green, Md.		SEP 18 1971		Robert E. Fisher, R.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. ADDRESS	
James J. Baranowski Inc.		806		2500	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 8572	
BIRTH NO. <u>M-62471 8572</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John T. Marshall, Jr.</u>				2. DATE AND HOUR OF DEATH <u>9/9/71 4:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Maryland</u>		B. COUNTY <u>Somerset</u>	
				C. CITY OR TOWN <u>TYLERTON</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>Smith Island</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-03</u>	9. AGE (in years last birthday) <u>68</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Ma</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Thomas Marshall</u>				14. MOTHER'S MAIDEN NAME <u>MAVIE TYLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-1540-9</u>		17. INFORMANT <u>J.V. Magri, M.D.</u>		ADDRESS <u>HOSPITAL</u>	
18. <u>189.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>GENERALIZED METASTASIS</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARCINOMA RT KIDNEY</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>JUNE 17/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA RT KIDNEY</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>5-7</u> 19 <u>71</u> to <u>9-9</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>9-9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Magri</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-9-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JULIO V. MAGRI</u> M.D.		23D. ADDRESS <u>South Baltimore General Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/12/1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Tylerton Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Tylerton - Somerset - Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>		25B. NAME OF REGISTRAR <u>Reed E. ...</u>		25C. FUNERAL DIRECTOR <u>Bradshaw & Sons - Crisfield, Maryland</u>			



BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 8573	
BIRTH NO. W-45271 8573									
1. NAME OF DECEASED (Type or Print) Marshall Williams RICHARD WILLIAMS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour September 8, 1971 12:10 A. M.					
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Cecil 5700	
9. DATE OF BIRTH Sept. 10, 1946		10. AGE (In years lost birthday) 24		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ralph A. Williams	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				14b. KIND OF BUSINESS OR INDUSTRY Construction		15. MOTHER'S MAIDEN NAME Mary M. Hall			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Viet Nam				17. SOCIAL SECURITY NO. 218-46-2786		18. INFORMANT Ralph A. Williams		ADDRESS R.D. 1 North East, Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 8 12 1 2 Multiple Injuries				CAUSE OF DEATH Multiple Injuries				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rte 222 - Cecil County 5700			
22D. TIME OF INJURY (APPROX.) 9-7-71 5:00 P.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in motorcycle-truck collision			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9/8/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/9/71		24C. NAME of CEMETERY or CREMATORY Bay View Methodist		24D. LOCATION (City, town, or county) (State) North East Md.			
25A. DATE OF DEATH RECEIVED SEP 13 1971				25B. NAME OF REGISTRAR D. E. Bailey, M.D.		25C. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS North East, Md.	

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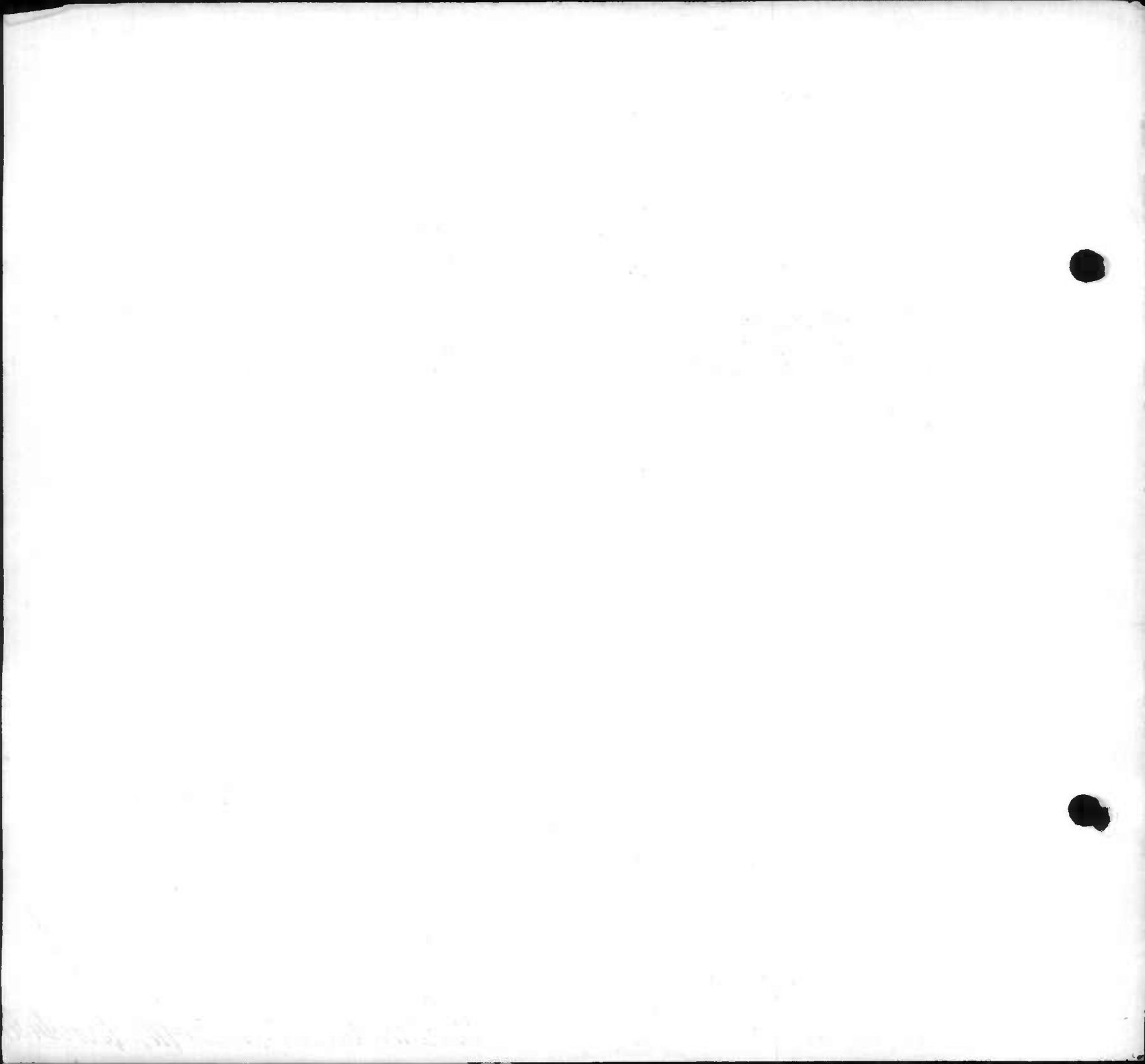
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

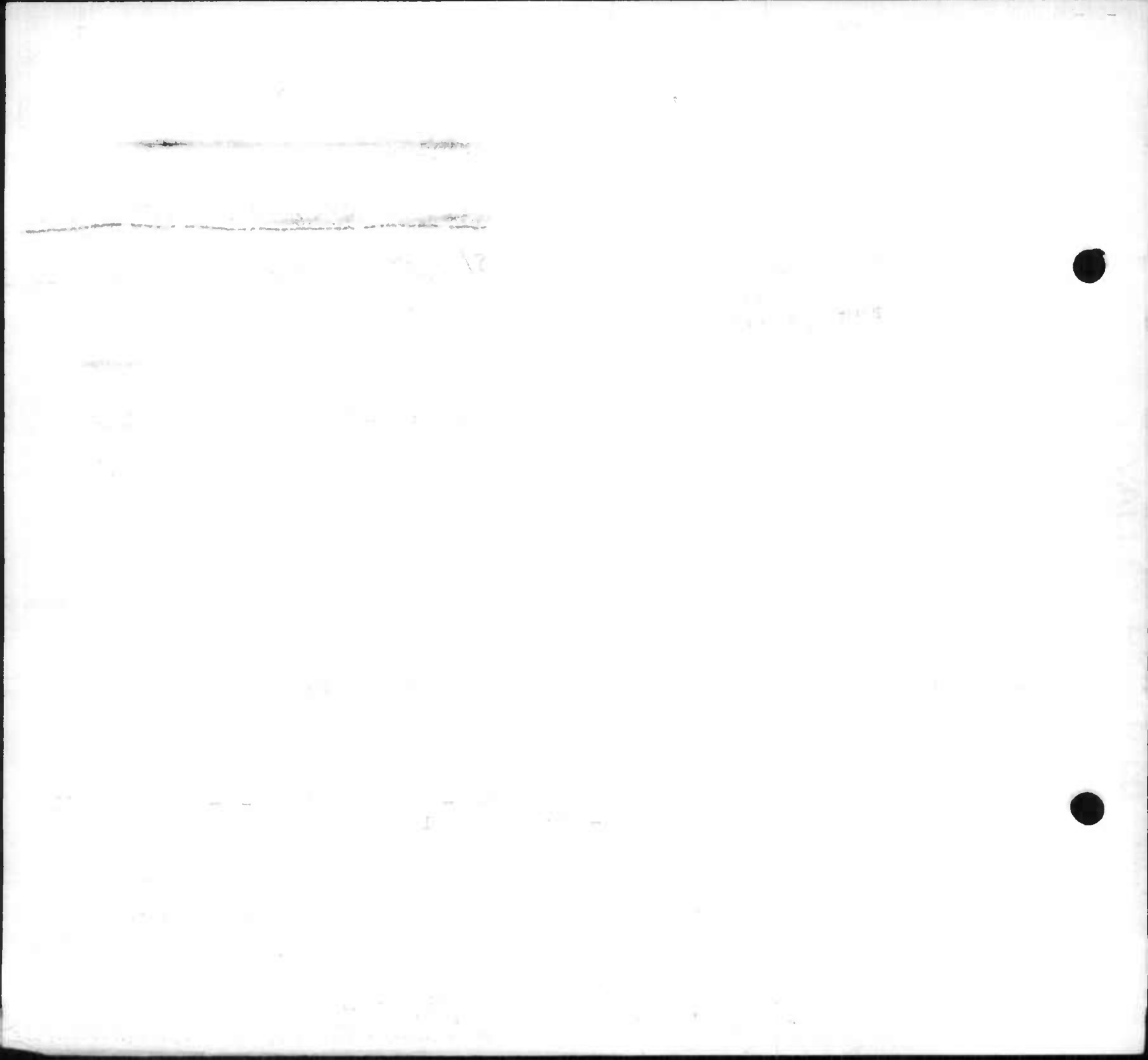
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8574	
M-000 71 8574				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) El Nora Mayo				2. DATE AND HOUR OF DEATH 9/8/71 1:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital				A. STATE MD	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY CITY	
				C. CITY OR TOWN CITY	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 808 Tessler St. 21201	
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/32	9. AGE (in years last birthday) 39
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME Wash Oliver				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.	
				17. INFORMANT Chert	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lymphoma, type not determined					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/8/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9/8/71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/9/71 19 71 to 9/8/71 19 71 that (I) (we) last saw the deceased alive on 7/9/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Georg C. Schumacher				23B. DATE SIGNED 9/8/71	
23C. PHYSICIAN'S NAME (Type) Georg C. Schumacher				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY OR CREMATORY Wm. A. Burial Cem. Balto.	
24D. LOCATION 11d.		24E. CITY, TOWN OR COUNTY Balto.			
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home	
				ADDRESS 3198 N. Broadway	



FUNERAL DIRECTOR: IMPORTANT

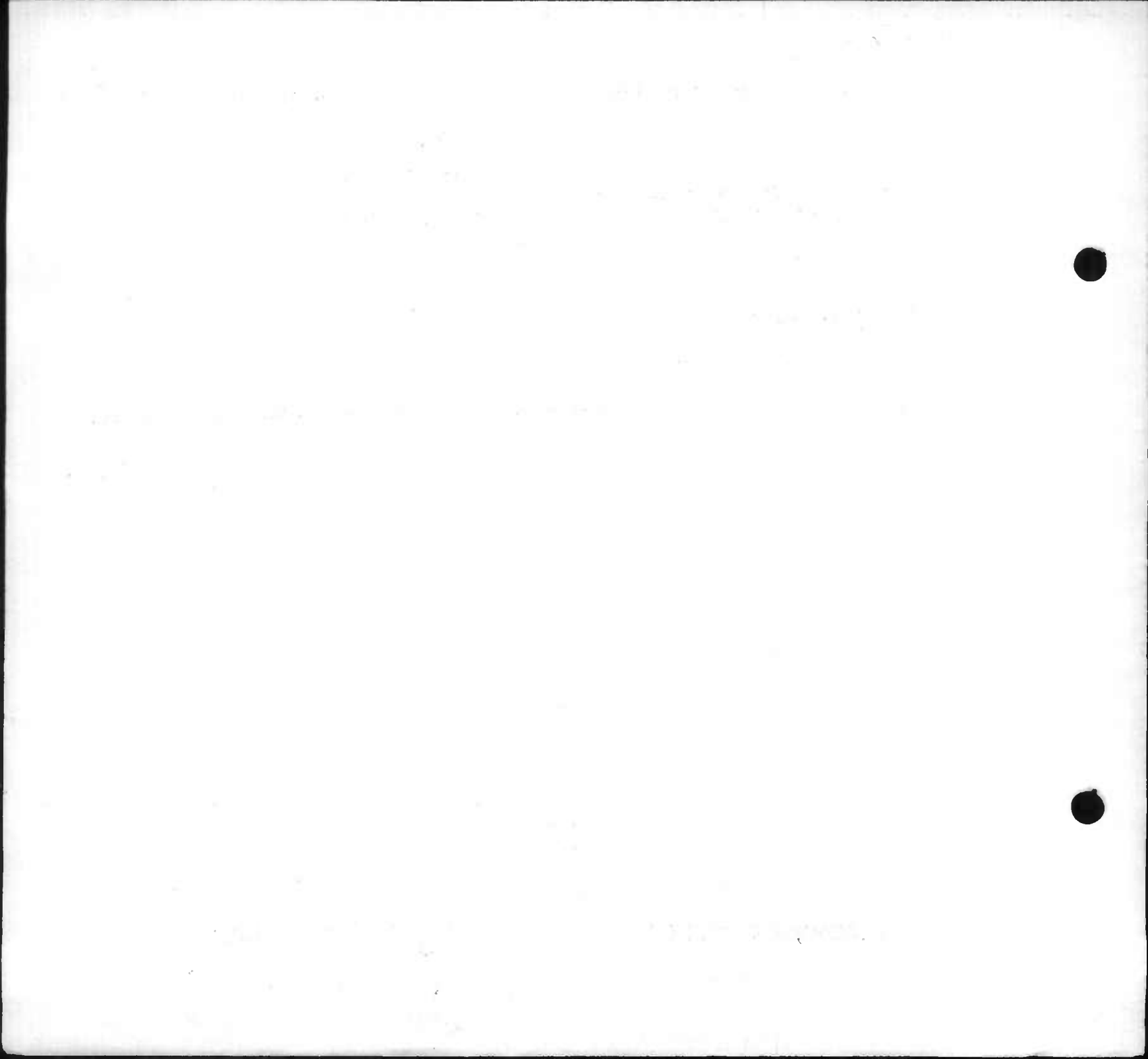
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
W-45271		8575				71 8575	
1. NAME OF DECEASED (Type or Print) WILLIAMS, DORA				2. DATE AND HOUR OF DEATH Sep 10, 1971 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY Hospitals BALTIMORE, MD. 21224				C. CITY OR TOWN BALTIMORE			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8/19/17			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years last birthday) 54		11. BIRTHPLACE (State or foreign country) South Carolina	
10B. KIND OF BUSINESS OR INDUSTRY NONE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES PEOPLES				14. MOTHER'S MAIDEN NAME NELLY HAMLIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213 26 1863		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertension cardiovascular disease Congestive heart failure Antecedent causes: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of breast Cerebrovascular accident Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >10 yrs.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-20-19 66 to 9-10-19 71 that (I) (we) last saw the deceased alive on 9-10-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Surat Sinasa, M.D.				23B. DATE SIGNED 9/10/71			
23C. PHYSICIAN'S NAME (Type) SURAT SINASA, M.D.				23D. ADDRESS 4940 Eastern Avenue 21224 BALTIMORE CITY HOSP. BAL, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/14/71		24C. NAME OF CEMETERY OR CREMATORY McLuburn Cem.		24D. LOCATION (City, town or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 13 1971		25B. NAME OF REGISTRAR R. E. F. Jones, Jr.		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3198 Ashford St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

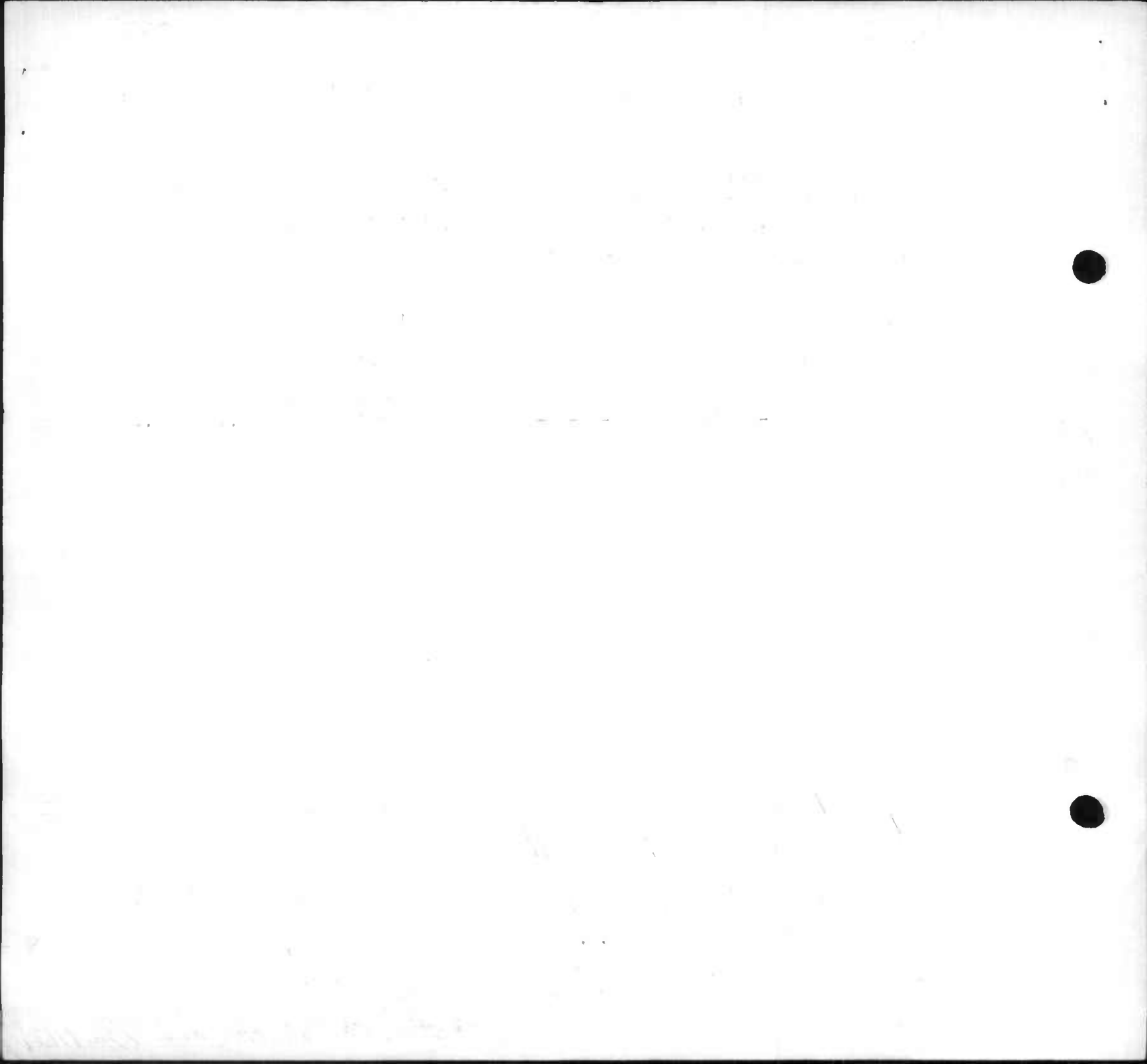
BIRTH NO. <u>G-342</u> <u>71</u> <u>8576</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>8576</u>	
1. NAME OF DECEASED (Type or Print) <u>Henry Edward Godlewski</u>			2. DATE AND HOUR OF DEATH <u>Sept. 1, 1971</u> <u>2: 52</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>3100 Wyman Parkway</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Pa.</u> B. COUNTY <u>V-35</u>		
5. SEX <u>M</u>			6. RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>2/10/20</u>		
9. AGE (In years last birthday) <u>51</u>			10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2nd Asst. Engineer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Seafaring</u>		
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Anthony Godlewski</u>			14. MOTHER'S MAIDEN NAME <u>Stella Burczynski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>140-16-0641</u>		
17. INFORMANT <u>Records- US PHS Hospital, Balto. Md.</u>			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>no</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 17</u> <u>19 71</u> to <u>Sept. 1</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>Sept. 1</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John S. Jaffe</u> <u>MD</u>			23B. DATE SIGNED <u>9/3/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>JOHN S. JAFFE, SA SURGEON (R)</u>			23D. ADDRESS <u>US PHS Hospital, Balto, Md</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>9-7-71</u>			24C. NAME OF CEMETERY or CREMATOR <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Jaffe</u>		



FUNERAL DIRECTOR: IMPORTANT

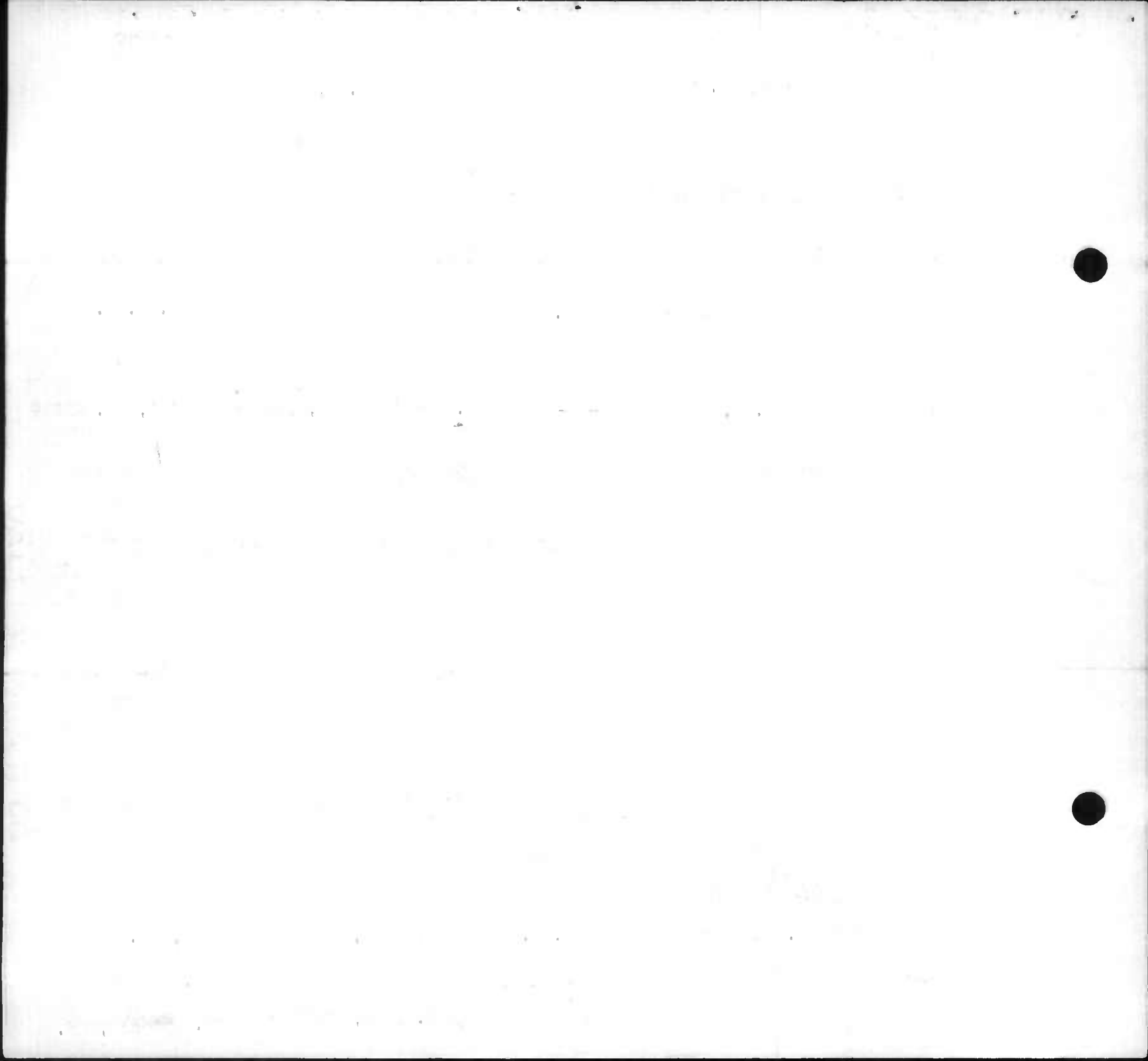
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-652 71 8577		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8577	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAWRENCE, NATHAN (Nance)		2. DATE AND HOUR OF DEATH 9/11/71 11:45 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1538			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3409 Fairview Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) St Mary's Co Md	
13. FATHER'S NAME John Lawrence		14. MOTHER'S MAIDEN NAME Mary Souie		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/19/18-7/9/19		16. SOCIAL SECURITY NO. 211-11-311-72		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		5 days	
		(C) Atherosclerotic cardiovascular dis.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 4th 19 71 to September 11th 19 71 that (I) (we) last saw the deceased alive on September 11th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Greenberg M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/13/71	
23C. PHYSICIAN'S NAME (Type) STEPHEN GREENBERG M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/71		24C. NAME OF CEMETERY OR CREMATORY Gettysburg Veterans Cemetery	
24D. LOCATION Gettysburg Pa		24E. STATE Pa		24F. CITY, TOWN, OR COUNTY Gettysburg Pa	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR John E. Taylor, M.D.	
		25D. ADDRESS 3900 Loch Raven Blvd. Balto. Md 21218			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 0578	
BIRTH NO. K-420 71 0578					
1. NAME OF DECEASED (Type or Print) George W. Kells			2. DATE AND HOUR OF DEATH Sept. 9, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 814 F Street		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/02	9. AGE (in years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Hugh Kells			14. MOTHER'S MAIDEN NAME Emma Downey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Navy W. W. I		16. SOCIAL SECURITY NO. 213-07-6608		17. INFORMANT (Wife) 814 F St. ADDRESS Mrs. Amelia Kells, Sparrows Point, Md. 21219	
18. 16211 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 10 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 7-3 19 71 to 7-9 19 71 that (I) (we) last saw the deceased alive on 7-9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. 23A. SIGNATURE Roger G. Windsor DEGREE M. D. 23B. DATE SIGNED 9/10/71 23C. PHYSICIAN'S NAME (Type) Roger G. Windsor 23D. ADDRESS 520 D Street, Sparrows Point, Md. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/13/71 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971 25B. NAME OF REGISTRAR John S. Duda 25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

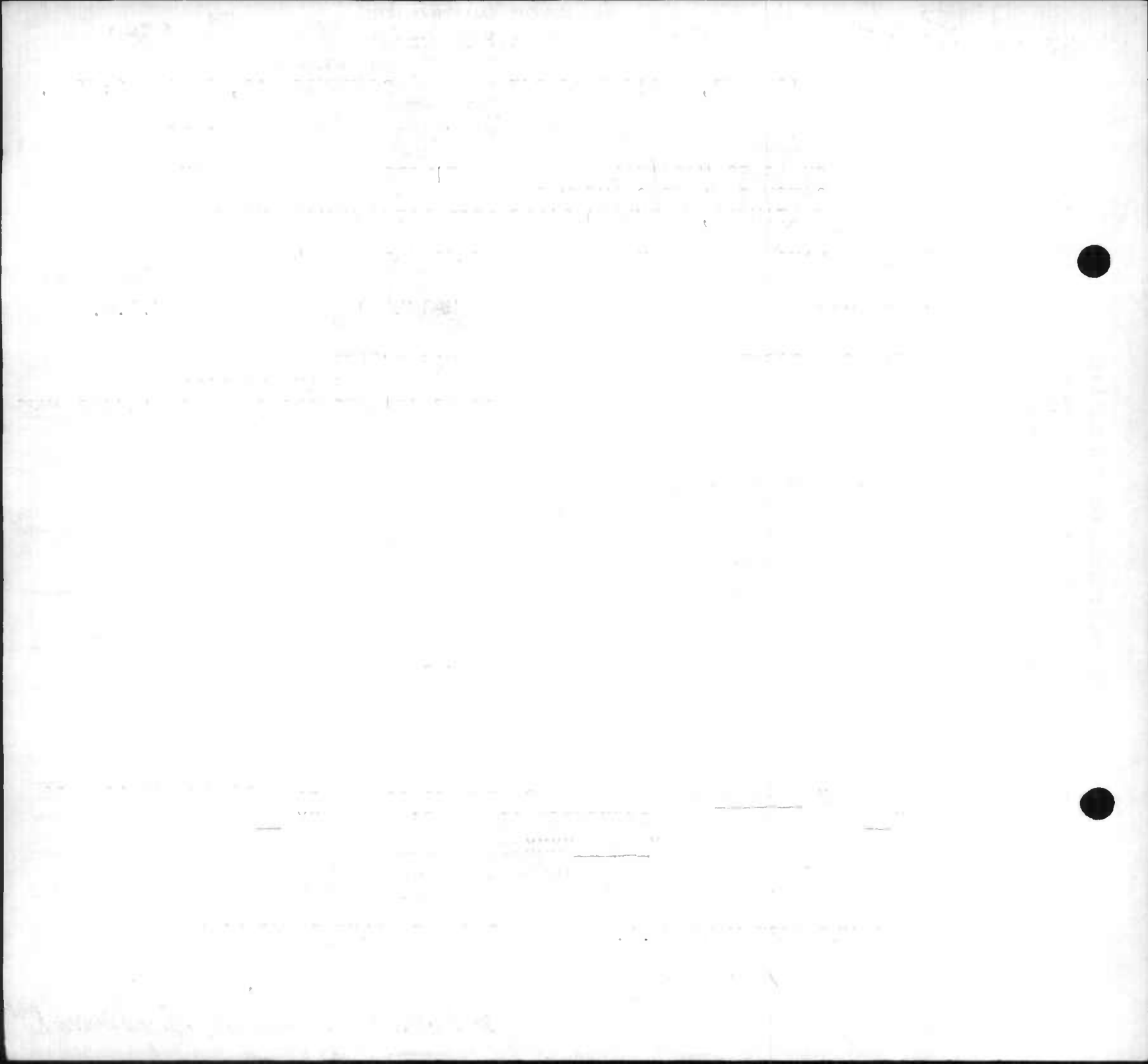
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	
CERTIFICATE OF DEATH					
BIRTH NO. K-412 71 2579					
1. NAME OF DECEASED (Type or Print) GOLDIE A. KELBAUGH			2. DATE AND HOUR OF DEATH 9/12/71 7-45a M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1307		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital Balt, Maryland 21218			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 712 W. 36th Street		
5. SEX F	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1898	9. AGE (In years last birthday) 72 years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY not known		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? AMERICAN					
13. FATHER'S NAME William Sullivan			14. MOTHER'S MAIDEN NAME Susie Armstrong		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Phillip Kelbaugh (same)
			ADDRESS		
18. 1888			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Infiltrating Carcinoma of the bladder (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 11, 1971 to Sept 12, 1971 that (I) (we) last saw the deceased alive on Sept 12, 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H. K. Shetty			23B. DATE SIGNED Sept 12, 1971		
23C. PHYSICIAN'S NAME (Type) Y. K. SHETTY			23D. ADDRESS Union Memorial Hospital Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/71		24C. NAME OF CEMETERY OR CREMATORY National	
24D. LOCATION Balt. Ind.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Philip E. Barber, M.D.		25C. FUNERAL DIRECTOR Walter E. Brown 3617 Chesapeake Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

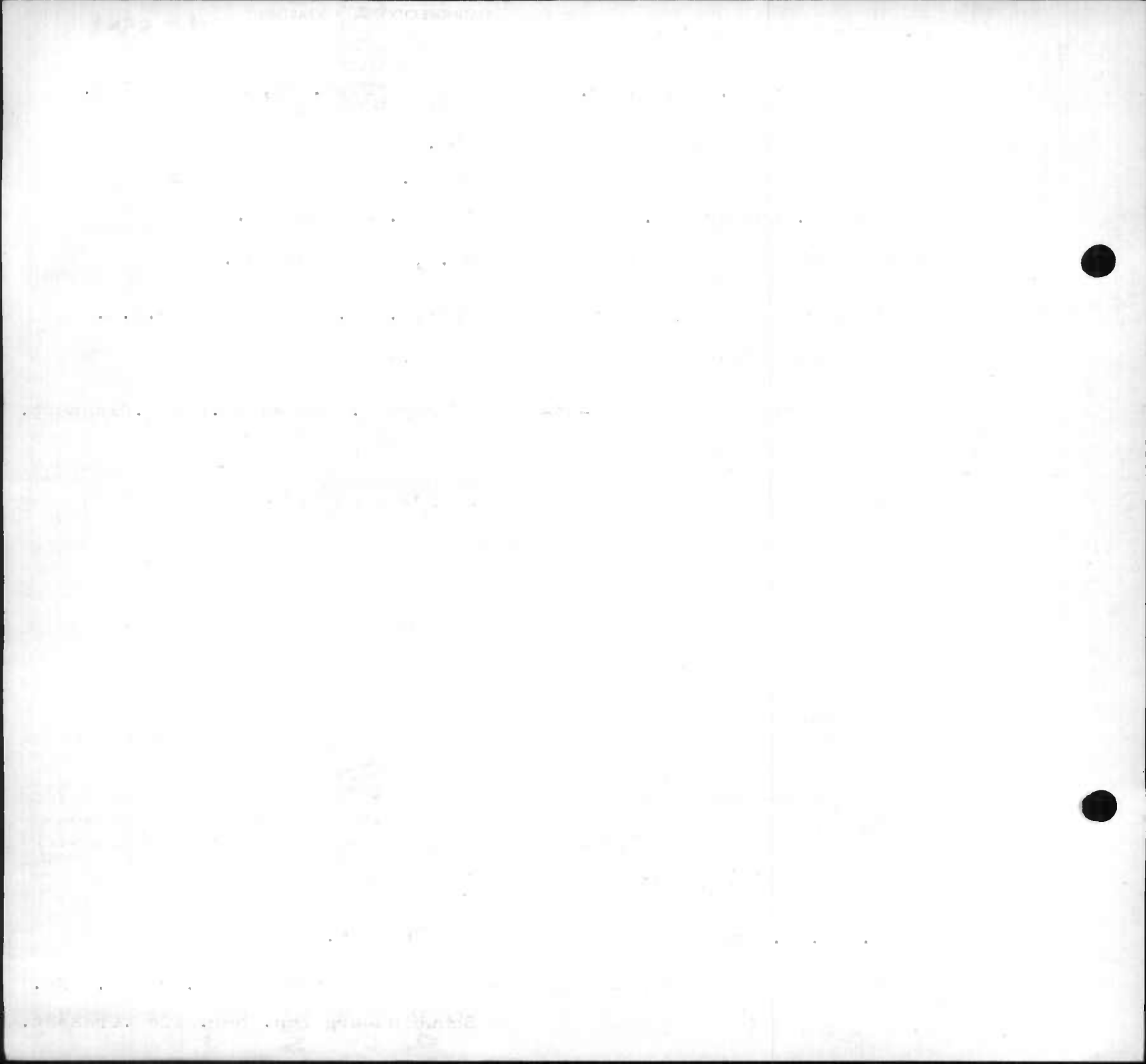
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8580</u>
BIRTH NO. <u>R-263</u>		71 8580		
1. NAME OF DECEASED (Type or Print) <u>RICHARTS, ELSIE MARGARET</u>		2. DATE AND HOUR OF DEATH <u>SEPTEMBER 13, 1971 2:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21230</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>06/18/97</u>		9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ANTON C. BOSSERT</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE KUPPER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>BALTO MD 21229</u> <u>ST AGNES' RECORDS CATON & WILKENS AVES</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute pulmonary edema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: <u>indetermined</u>				
(C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <u>SEPTEMBER 12</u> 19 <u>71</u> to <u>SEPTEMBER 13</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>SEPTEMBER 13</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (and not) view the body after death.				
23A. SIGNATURE <u>Paul Westphalen</u> D.D. DEGREE				23B. DATE SIGNED <u>9/13/71</u>
23C. PHYSICIAN'S NAME (Type) <u>PAULO WESTPHALEN M.D.</u>		23D. ADDRESS <u>CATON & WILKENS AVE 21229</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/16/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>
24D. LOCATION <u>Woodlawn Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Raymond D. Link-Plan Bureau</u>		25C. FUNERAL DIRECTOR <u>Raymond D. Link-Plan Bureau</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

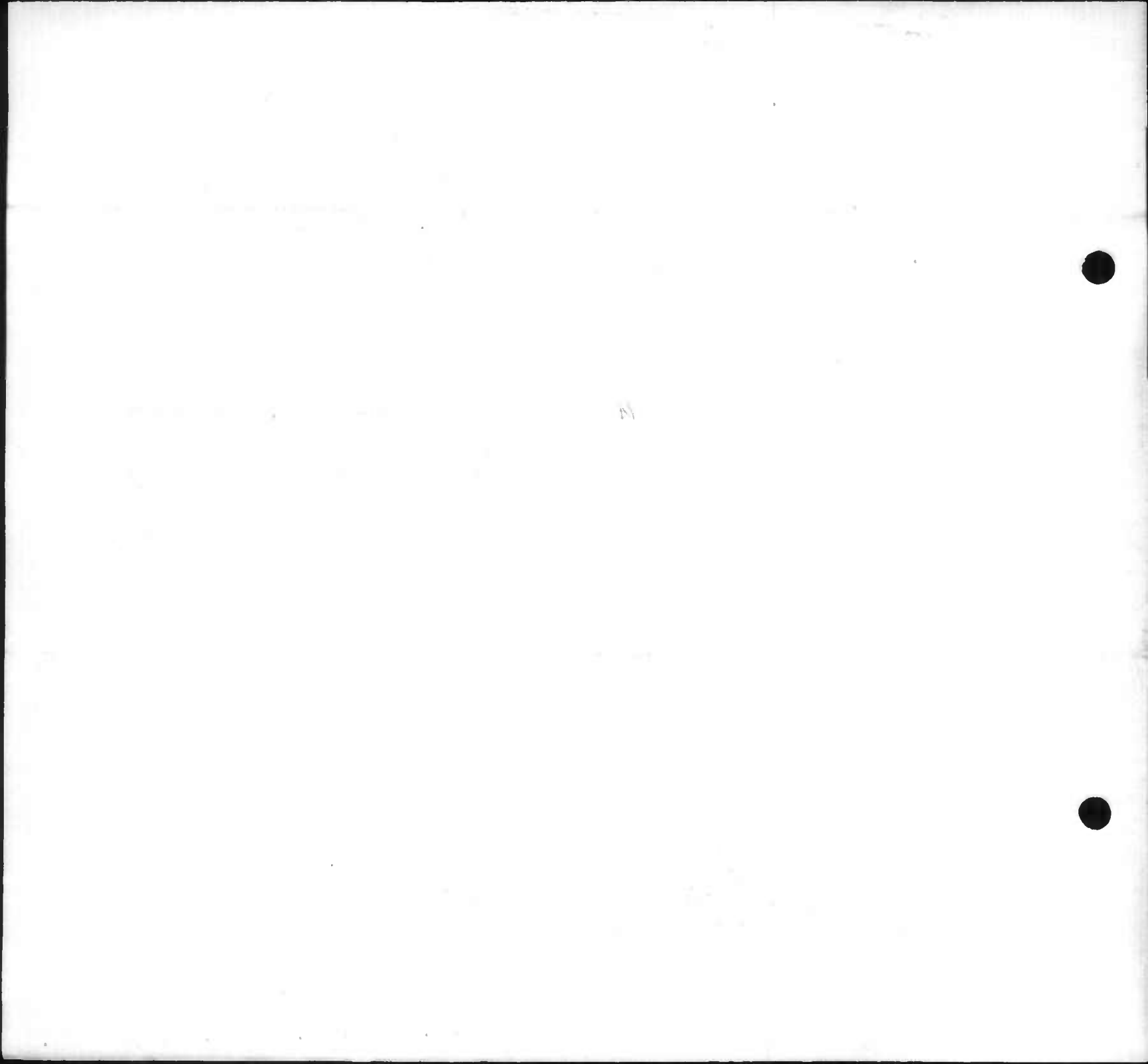
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8581	
E-355 71 8581				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) George V. Eidman Sr.			
2. DATE AND HOUR OF DEATH Sept. 11, 1971 11 A.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1111 W. Hamburg St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.	
5. SEX male		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 1, 1905		9. AGE (In years last birthday) 66 yrs.		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Rices Bakery		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Eidman		14. MOTHER'S MAIDEN NAME Lillian Reibert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 218-03-7010		17. INFORMANT George V. Eidman Jr. ADDRESS 927 S. Oldham St.	
18. 593.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Renal Insufficiency and Uremia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with electrolyte imbalance		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH chronic - many years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Bronchitis and Heart Failure		19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 2-28 1971 to 9-11 1971 , that (I) (we) last saw the deceased alive on 7-28 1971 and that, in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (any) (all) (did not) view the body after death. (Signed with Medical Examiner)					
23A. SIGNATURE William R. Law		23B. DATE SIGNED 9-13-71		23C. PHYSICIAN'S NAME (Type) Dr. Wm. R. Law	
23D. ADDRESS 714 York Rd.		23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Frederick Ave. Balto. Md.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Reise E. Ely, M.D.		25C. FUNERAL DIRECTOR Schweinsberg Fun. Ser. 1126 W. Cross St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8582	
S-520 71 8582		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Anna M. Snack</i>		September 9, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 477 N. East Avenue</i>		A. STATE <i>Maryland</i> B. COUNTY <i>2610</i>	
		C. CITY OR TOWN <i>Baltimore,</i>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>477 N. East Avenue</i>	
5. SEX <i>F.</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/27/77</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>94</i>
13. FATHER'S NAME <i>John Deasal</i>		14. MOTHER'S MAIDEN NAME <i>Mary Weidner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>4422</i>	
		17. INFORMANT ADDRESS <i>Miss May Snack 477 N. East Avenue</i>	
18. <i>1124 I</i>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIOSCL. C. V. D. DISEASE</i> <i>17 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ARTERIOSCL. Generalized</i> <i>10 years</i>	
		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>9/13/71</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>9/9/71</i> that (I) (we) last saw the deceased alive on <i>9/8/71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Benny B. Moses, MD</i>		23B. DATE SIGNED <i>9/10/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>BENNY B. MOSES, MD</i>		23D. ADDRESS <i>488 N. Luzerne Baltimore, Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>9/13/71</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1971</i>	25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>	25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8583</u>	
L-520 71 8583		BIRTH NO. <u>71 8583</u>			
1. NAME OF DECEASED (Type or Print) <u>LYNCH, ANNA ADELINE</u>			2. DATE AND HOUR OF DEATH <u>SEPTEMBER 11, 1971 7:45 PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2841</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>SETON INSTITUTE-6400 WABASH AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04 05 '03</u>	9. AGE (In years last birthday) <u>68</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		
13. FATHER'S NAME <u>HARRY C LYNCH</u>			14. MOTHER'S MAIDEN NAME <u>MARY E. (MCBRIDE)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>1-62-44-6928</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>GI bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Poss. peptic ulcer</u>			17. INFORMANT ADDRESS <u>ST AGNES RECORDS-BALTO MD 21229</u>		
19. DATE OF OPERATION			20. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>ASCVD</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 11 19 71</u> to <u>SEPTEMBER 11 19 71</u> that (I) (we) last saw the deceased alive on <u>SEPTEMBER 11 19 71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Rahman Karimi</u>			23B. DATE SIGNED <u>9/11/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>RAHMAN KARIMI</u>			23D. ADDRESS <u>St Agnes Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>9/15/71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre Cemetery-Wyndmoor, Mt. City, Pa.</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 21229</u>		
25A. DATE RECD BY HEALTH DEPT. <u>SEP 14 1971</u>			25B. NAME OF REGISTRAR <u>John E. Moore</u>		
25C. FUNERAL DIRECTOR <u>3000 E. Baltimore St.</u>			25D. ADDRESS <u>Baltimore, Md. 21229</u>		

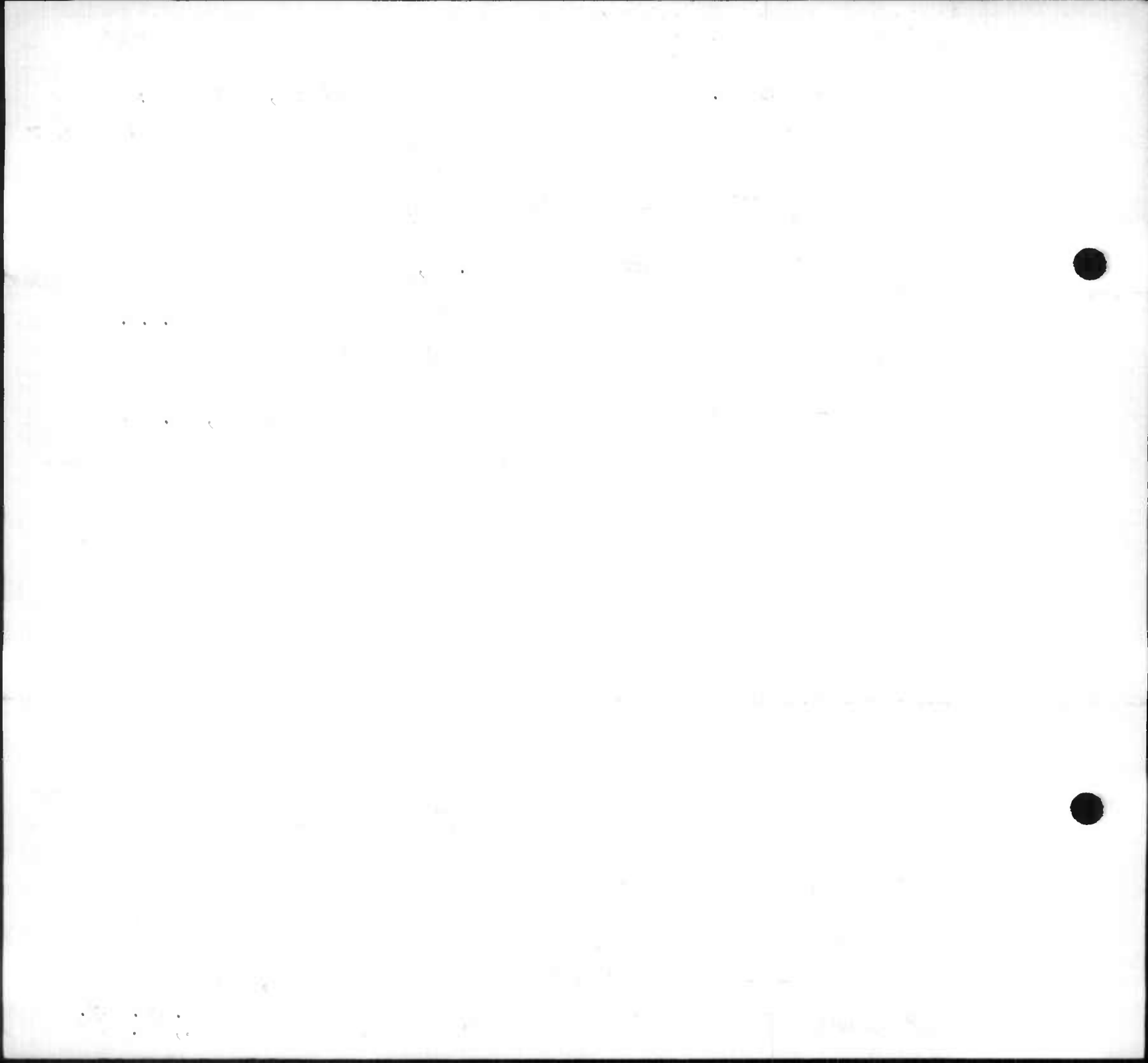
Adm. to Selon

4/1938

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8584	
E-360 71 8584		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Josephine M. Eder</i>		2. DATE AND HOUR OF DEATH <i>September 9, 1971 15:05 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2303</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1926 Light Street</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 19, 1902</i>
9. AGE (In years last birthday) <i>69</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Durika</i>		14. MOTHER'S MAIDEN NAME <i>Veronica Merick</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215 09 4367 B</i>	
17. INFORMANT <i>Mary Jo Cleckner</i>		ADDRESS <i>8423 Kenton Road Pasadena, Md. 21122</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sent Coronary Occlusion</i> (B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardio Vascular Disease</i> (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>9-10-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <i>March 1970</i> to <i>9-9-71</i> that (I) (we) last saw the deceased alive on <i>9-9-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Rolando V. Goco MD</i>		23B. DATE SIGNED <i>9-10-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rolando V. Goco MD</i>		23D. ADDRESS <i>707 E. Fort Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-13-71</i>	
24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Jaber, M.D.</i>	
25C. FUNERAL DIRECTOR <i>McCurdy Funeral Home</i>		ADDRESS <i>130 E. Ft. Ave. Balto., Md. 21230</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8585
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Regina Reinhardt Reinhardt</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>September</u> Day <u>10</u> Year <u>1971</u> Hour <u>6:51</u> PM <u>M.</u> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>September</u> Day <u>10</u> Year <u>1971</u> Hour <u>6:51</u> PM <u>M.</u>	
6. SEX <u>Female</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2102</u>	
9. DATE OF BIRTH <u>12-11-52</u>		10. AGE (in years last birthday) <u>19</u> 18 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		15. MOTHER'S MAIDEN NAME <u>Gertrude F. Kidwell</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>213 60 3464</u>	
18. INFORMANT <u>Leroy Reinhardt</u>		ADDRESS <u>1240 Cleveland St Baltimore, Maryland 21230</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Barbiturate overdose (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>21</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Unknown</u>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Unknown</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <u>Unknown</u>		22F. HOW DID INJURY OCCUR? <u>Ingested overdose of barbiturates</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> September 11, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-14-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A.A.Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>18 E. E. Funeral Home</u>		ADDRESS <u>130 C. Fort Avenue Balto., Md. 21230</u>	

Letter from M.E.'s office

9-27-71

M.H.

1

T-620

71

8586

BALTIMORE CITY HEALTH DEPARTMENT

71

8586

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD TUREK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1932 Wilkins Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1971 8:35 A.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 15, 1900		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		14B. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1917		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Frank M. Turek		15. MOTHER'S MAIDEN NAME Elizabeth Fuka	
18. INFORMANT Margaret Marx Box 234 A Rt. 15 Balto 21220		ADDRESS	
19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 9		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 9, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Gable	
25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home		ADDRESS 1407 Eastern Ave.	

8388

Aug. 14, 1900

Baltimore

river

1900

Trucking Co.

Frank H. Durr

Elizabeth

Postmaster: Box 234 A W. 12th St. 21200

8388

Aug. 14, 1900

Baltimore

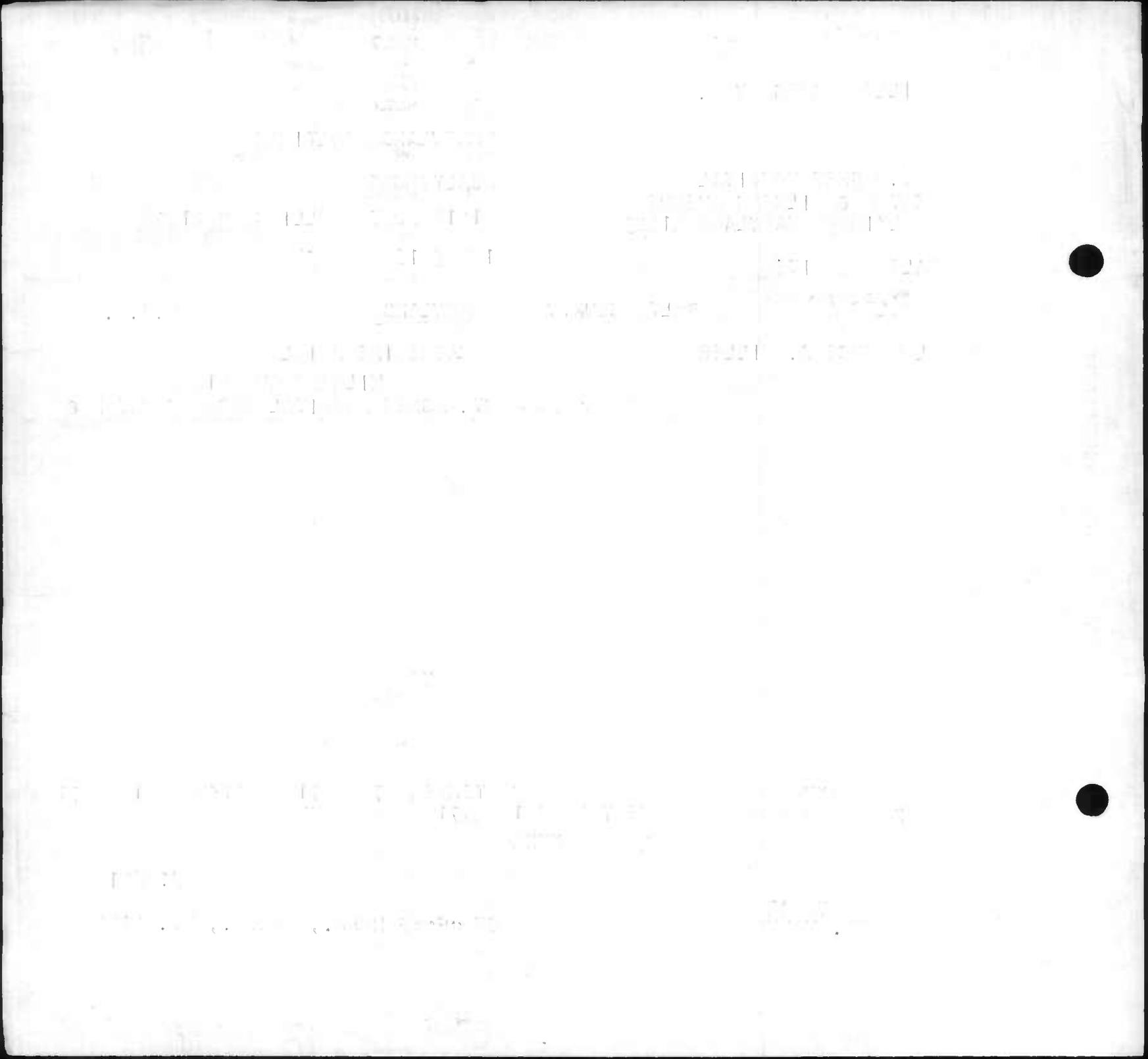
river

Trucking Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

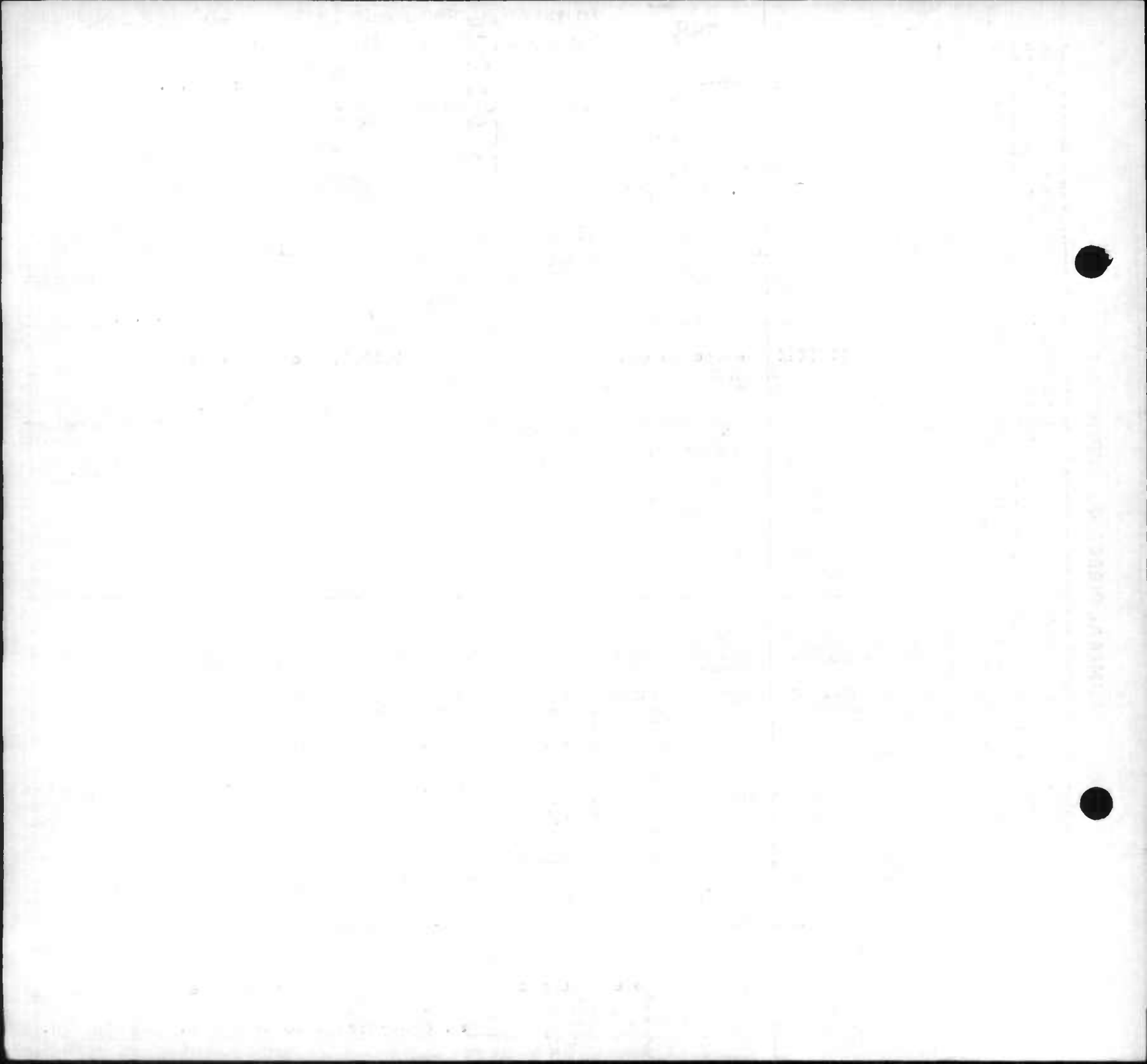
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8587</u>	
BIRTH NO. <u>M-460</u> <u>71 8587</u>		1. NAME OF DECEASED (Type or Print) <u>MILLER GREGORY H.</u>			
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUE</u> <u>BALTIMORE MARYLAND 21229</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 29 16</u>		9. AGE (In years last birthday) <u>54</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO COUNTY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>LAWRENCE G. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE HUISLER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-2256</u>		17. INFORMANT <u>WILKENS AVE 21229</u> ADDRESS <u>ST. AGNES HOSPITAL RECORDS CATON &</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Thrombosis Right Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Posterior Septal infarct.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CVA - Intracerebral Hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>SEPTEMBER 07</u> 19 <u>71</u> to <u>SEPTEMBER 10</u> 19 <u>71</u> that <u>X</u> (we) last saw the deceased alive on <u>SEPTEMBER 10</u> 19 <u>71</u> and that <u>XX</u> (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (do) (do) view the body after death.					
23A. SIGNATURE <u>Dr. Mahmood</u>		23B. DATE SIGNED <u>9/10/71</u>		23C. PHYSICIAN'S NAME (Type) <u>TARIQ DR. MAHMOOD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept. 13-1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Annetta Md.</u>		24E. IS TOL		24F. NAME OF REGISTRAR <u>Harley L. Bannanough F. H.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

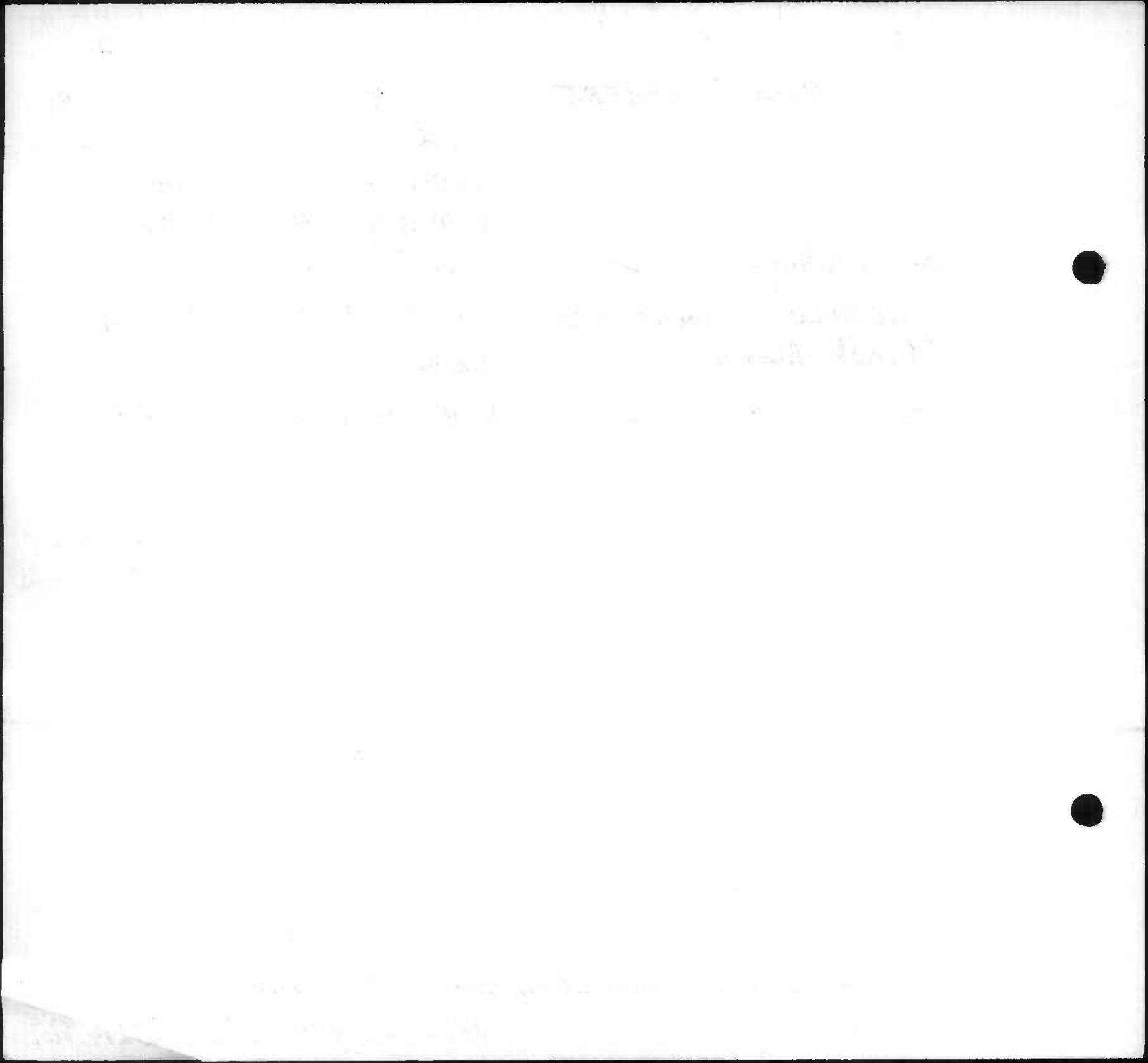
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8588</u>	
B-620 71 8588 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Bowers, George Lowman</u>			2. DATE AND HOUR OF DEATH <u>9/10/71 8:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital 301 St. Paul Place</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>unknown</u> B. COUNTY <u>00-00</u> C. CITY OR TOWN <u>Unknown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Unknown</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/30/09</u>	9. AGE (in years) <u>62</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>George Bowers</u>		
14. MOTHER'S MAIDEN NAME <u>Delia Netter</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Unknown</u>		
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT ADDRESS <u>Cunningham Funeral Home W. Virginia</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3000</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) _____		21E. INJURY OCCURRED _____		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from <u>July 1</u> 19 <u>71</u> to <u>Sept 11</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/10/71</u> 19 <u>71</u> and that (1) (my) (our) apinlan death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles J. Pancelotta M.D.</u>				23B. DATE SIGNED <u>9/11/71</u>	
23C. PHYSICIAN'S NAME (Typed) <u>Charles Lancellotta</u>				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-13-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bowers Cemetery</u>	
24D. LOCATION <u>Charleston, West Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson, Inc. Towson, Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

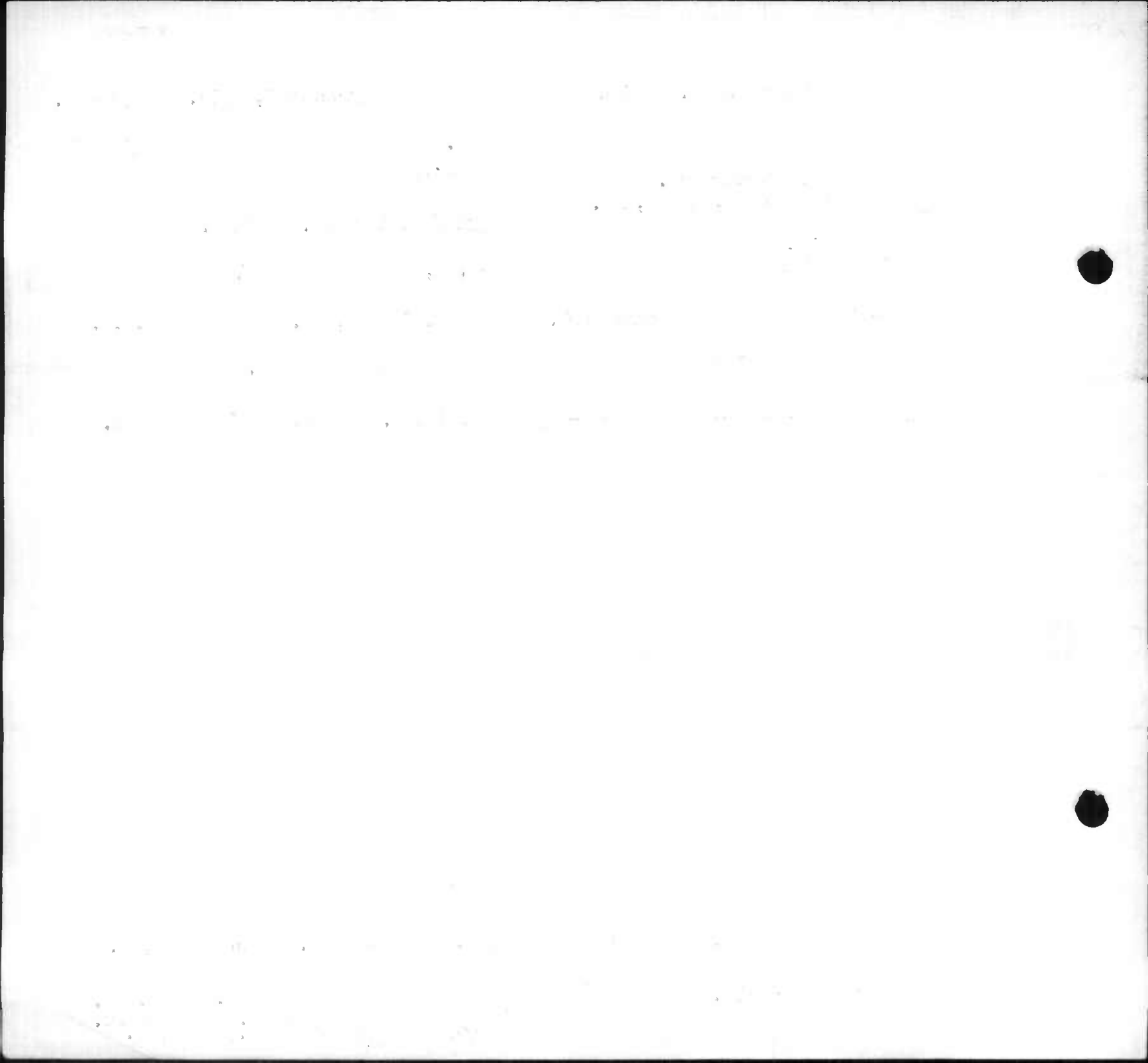
E-163		71 8589		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8589	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARY E. EBBERT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 9-9-71 3:30 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION Montebello State Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 2744			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6000 Alta Ave. #21206.							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-95	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) NEFF, OHIO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dennis				14. MOTHER'S MAIDEN NAME Amelia Baker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 270-10-0291		17. INFORMANT ROBERT J. EBBERT		ADDRESS SAME.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Terminal Pneumonia 18 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Possible CVA DUE TO, OR AS A CONSEQUENCE OF:		18 days	
				(C) arteriosclerotic cardiovascular disease		many years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 27 1969 to Sept. 9 1971 that (I) (we) last saw the deceased alive on Sept. 9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corazon Cuevas, M.D.				23B. DATE SIGNED 9-9-71		23C. PHYSICIAN'S NAME (Type) CORAZON CUEVAS M.D.	
23D. ADDRESS Montebello State Hosp.				23E. FUNERAL DIRECTOR Charles J. Gailer		23F. ADDRESS 6224 EASTERN AVE. BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., BA. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles J. Gailer		25D. ADDRESS 6224 EASTERN AVE. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-263 71 8590		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71-8590	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPHINE C. DECKRET		2. DATE AND HOUR OF DEATH September 8, 1971. 9:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3116 Foster Ave. Baltimore, 21224, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3116 Foster Ave. # 21224.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1884	9. AGE (In years last birthday) 87	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Remlein			
14. MOTHER'S MAIDEN NAME Mary Salzig.		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-03-4455		17. INFORMANT Caroline E. Deckret			
18. CAUSE OF DEATH 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 9/10/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Generalized out Sep. 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Same.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1969 to June 1971 that (I) (we) last saw the deceased alive on June 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julius H. Goodman		23B. DATE SIGNED 9/10/71		23C. PHYSICIAN'S NAME (Type) JULIUS H. GOODMAN	
23D. ADDRESS 9 S. Highland Ave., Balto, 21224, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9-11-71		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) 4430 Belair Rd., Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Charles S. Gailer, Balto., 21224, Md.	



1
R-140

P-634 71 8591
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 8591
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Johnnie (Ruplow) Pretlow		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 12, 1971 Hour 4:10 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 12, 1971 Hour 4:10 AM	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/2/19		10. AGE (In years lost birth day) 52	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes W W 2		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs Lugenia Pretlow, same		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED September 12, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/71	
24C. NAME of CEMETERY or CREMATORY MT Auburn C metry		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W 4th Av	

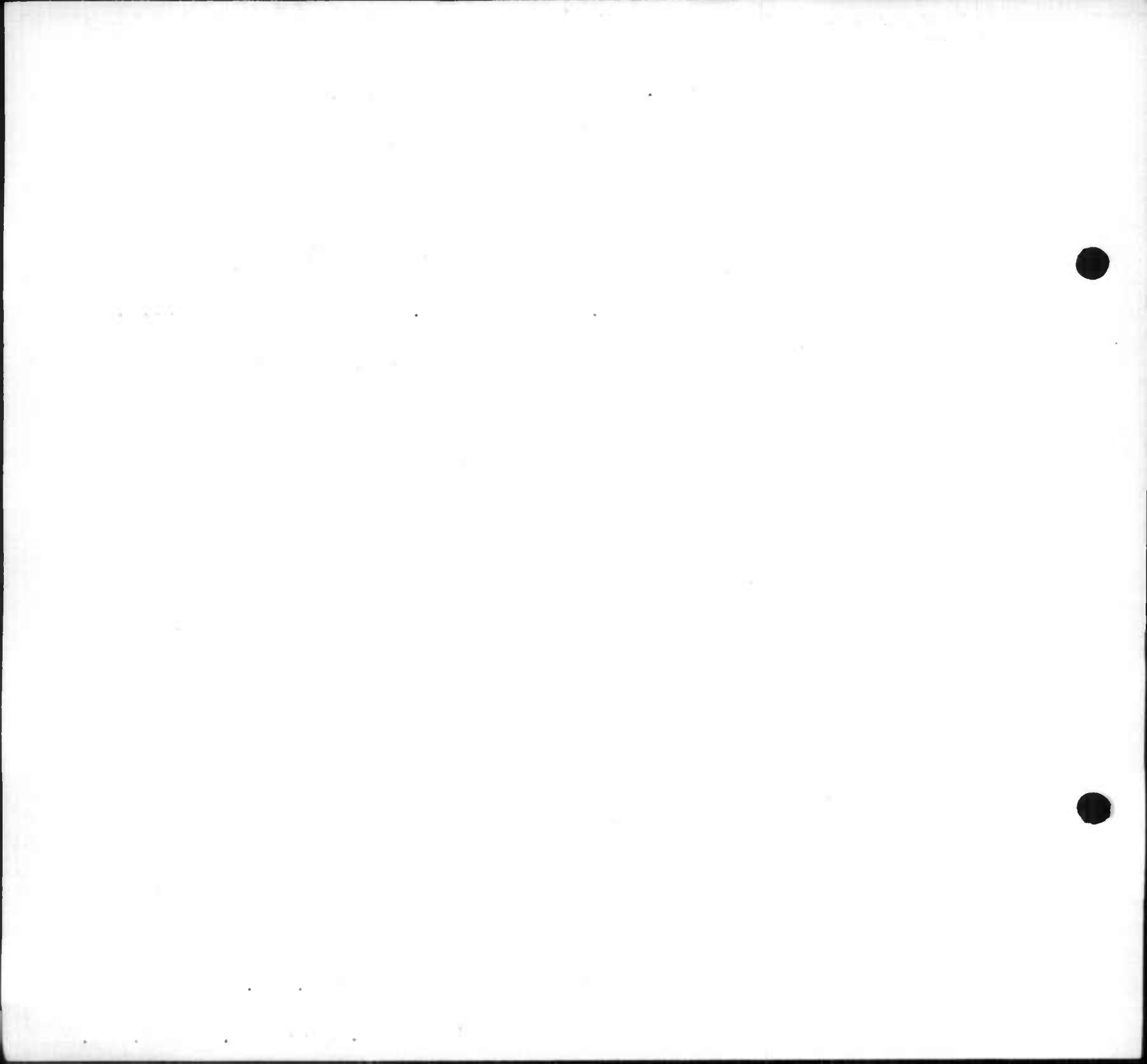
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

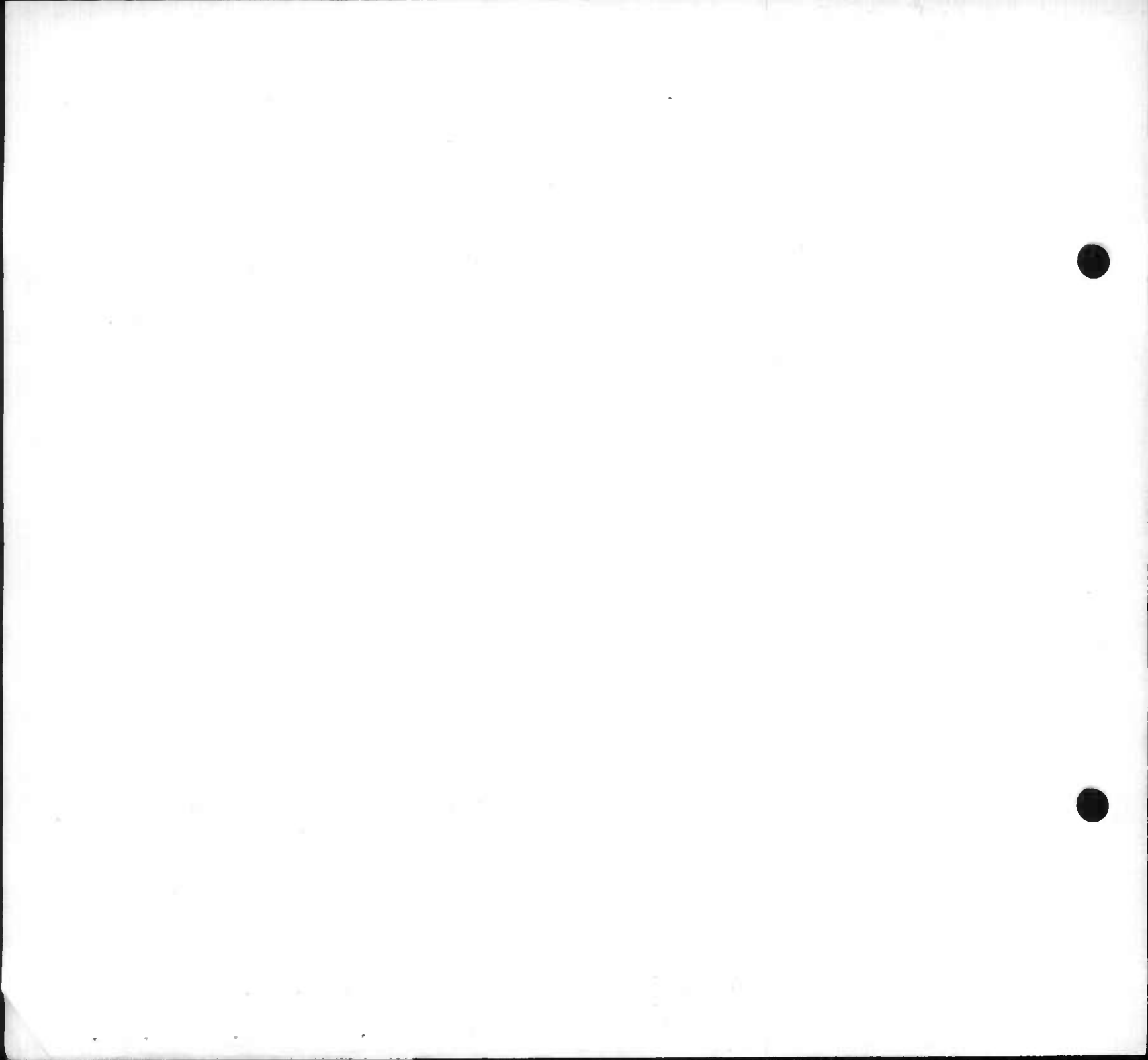
Z-300,1 8592		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8592	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Zito, Dorothy M.		2. DATE AND HOUR OF DEATH Sent. 12, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 45 Good Samaritan Hospital		Maryland C. CITY OR TOWN Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7901 Eastdale Road			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-18	9. AGE (In years last birthday) 58 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10B. KIND OF BUSINESS OR INDUSTRY Lebow Bros.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Graber		14. MOTHER'S MAIDEN NAME Marie Stronsky	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-09-8241		17. INFORMANT Hospital Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of uterus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7-8-71 19 to 9-12-71 19 that (1) (we) last saw the deceased alive on 9-12-71 19 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE Michael Colvin, MD		23B. DATE SIGNED Sept. 12, 1971			
23C. PHYSICIAN'S NAME (Type) Michael Colvin, M.D.		23D. ADDRESS Good Samaritan Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

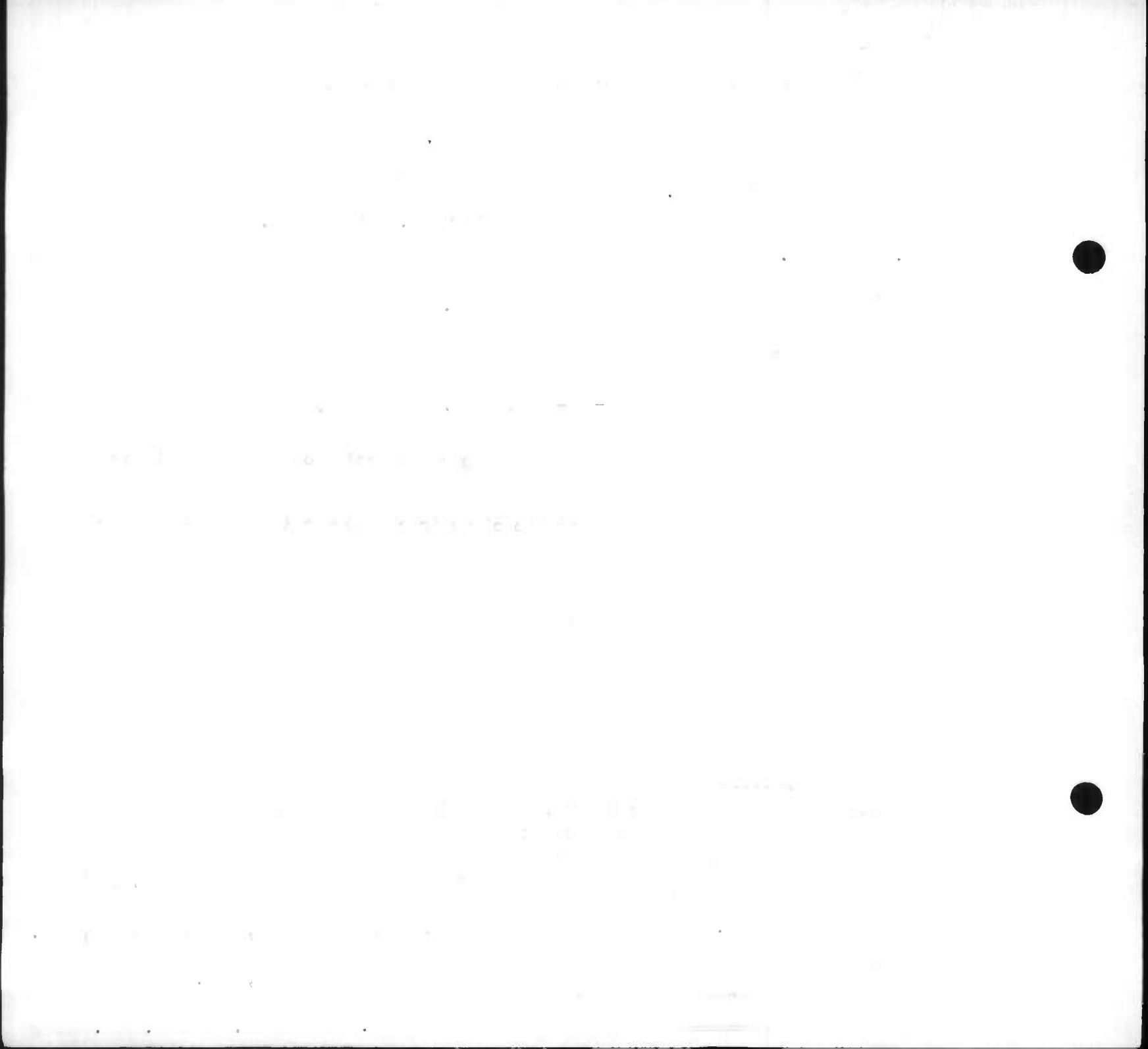
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-52571 8593		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		★ REG. NO. 71 8593	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Johnson, Rose M.		2. DATE AND HOUR OF DEATH Sept. 11, 1971 8:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hospital		E. STREET AND NUMBER 2930 Summit Avenue 21234		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX F	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 11-10-23	10. AGE (In years last birthday) 47	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Giant Food		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerry Iacarino		14. MOTHER'S MAIDEN NAME Mary Tufano	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-12-7452		17. INFORMANT Hospital Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Reticulum Cell Sarcoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-2-71 19 to 9-11-71 19 that (I) (we) last saw the deceased alive on 9-11-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Michael Colvin, M.D.		23B. DATE SIGNED 9-11-71	
23C. PHYSICIAN'S NAME (Type) Michael Colvin, M.D.		23D. ADDRESS Good Samaritan Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 14 1971		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR Leonard J. Ruck Inc.		24H. ADDRESS Balto. Md.			



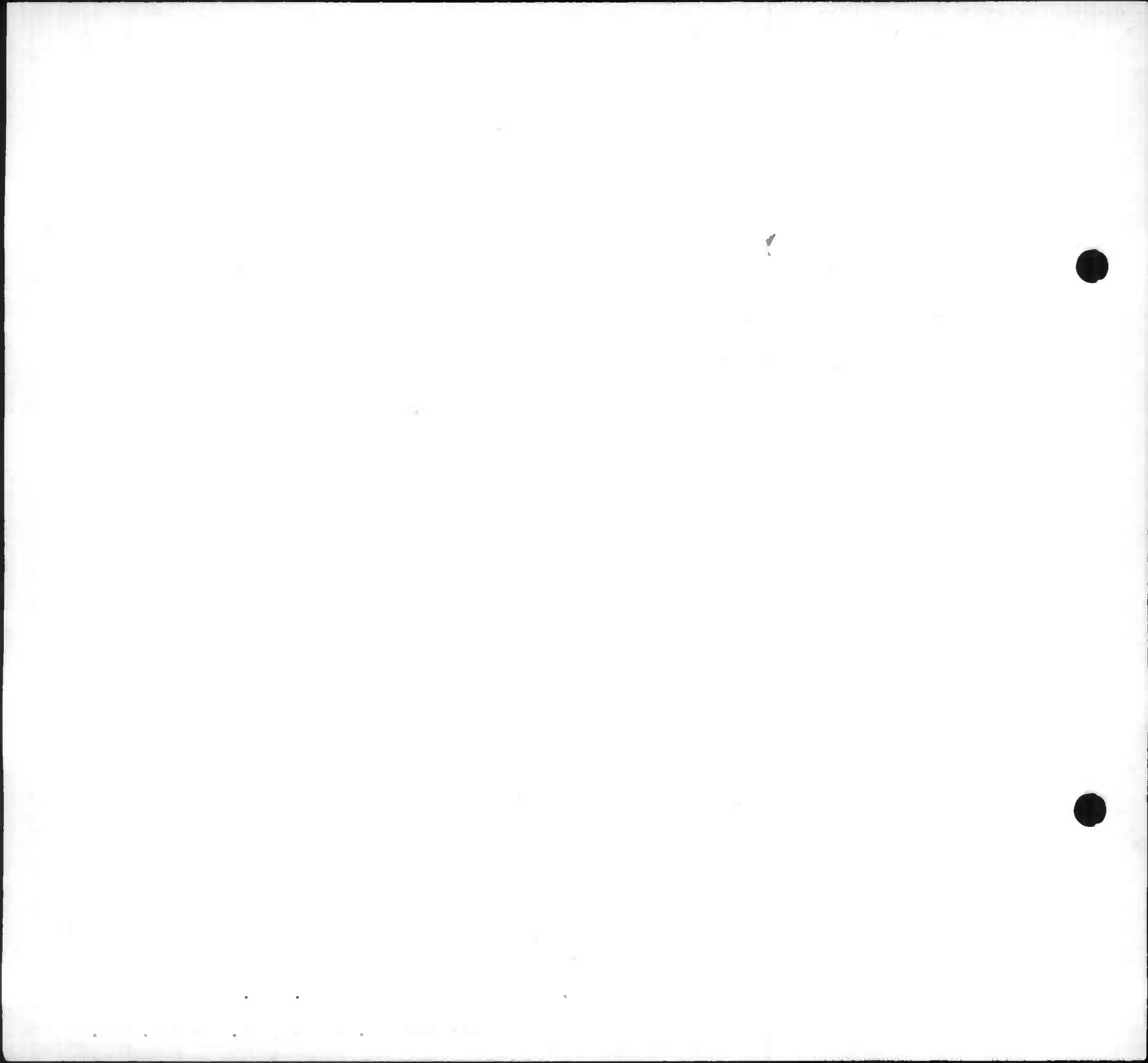
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-460		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8594	
71 8594		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Arthur P. Wheeler		2. DATE AND HOUR OF DEATH 9/10/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 806			
5. SEX M.		6. RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/27/1907		9. AGE (In years last birthday) 64		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Arthur B. Wheeler		14. MOTHER'S MAIDEN NAME Ethel Promrose	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-03-1881		17. INFORMANT ADDRESS Mrs. Marion M. Wheeler same	
18. 4107 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease		10 years	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gout					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was) XXXX attended the deceased from 19 60 to August 19 71 that (I) (was) last saw the deceased alive on August 30, 19 71 and that in (my) (my) XXXX opinion death occurred on the date and hour and from the causes stated above. (I) (was) XXXX (did) (did not) view the body after death.					
23A. SIGNATURE <i>Millard T. Traband</i>		23B. DATE SIGNED 11 Sept. 1971		23C. PHYSICIAN'S NAME (Type) Millard T. Traband	
23D. ADDRESS 1811 N. Rolling Road, Catonsville, Md.		23E. ATTENDING PHYSICIAN Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 14 1971			
24F. NAME OF REGISTRAR Robert E. Barber, M.D.		24G. FURNERAL DIRECTOR Leonard J. Ruck Inc.		24H. ADDRESS Balto. Md.	



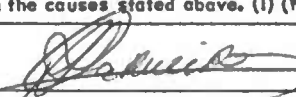
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 71 8595		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8595	
1. NAME OF DECEASED (Type or Print) <u>Charles R. Boesche</u>				2. DATE AND HOUR OF DEATH <u>September 10, 1971 5:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>902</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1504 Windemere Ave. 21218</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-81</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Boesche</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-6321-A</u>		17. INFORMANT ADDRESS <u>Mrs. Beatrice Canter 3605 Loch Raven</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Arrest</u> (B) <u>Pleural Effusion (Blunt)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cancer of Sigmoid Colon</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>20 days</u> <u>Months?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>August 20, 1971</u> to <u>Sept 10, 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 10, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Richard C. Keown MD.</u>				23B. DATE SIGNED <u>9/10/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard C. Keown MD.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/14/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Vetter, MD.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

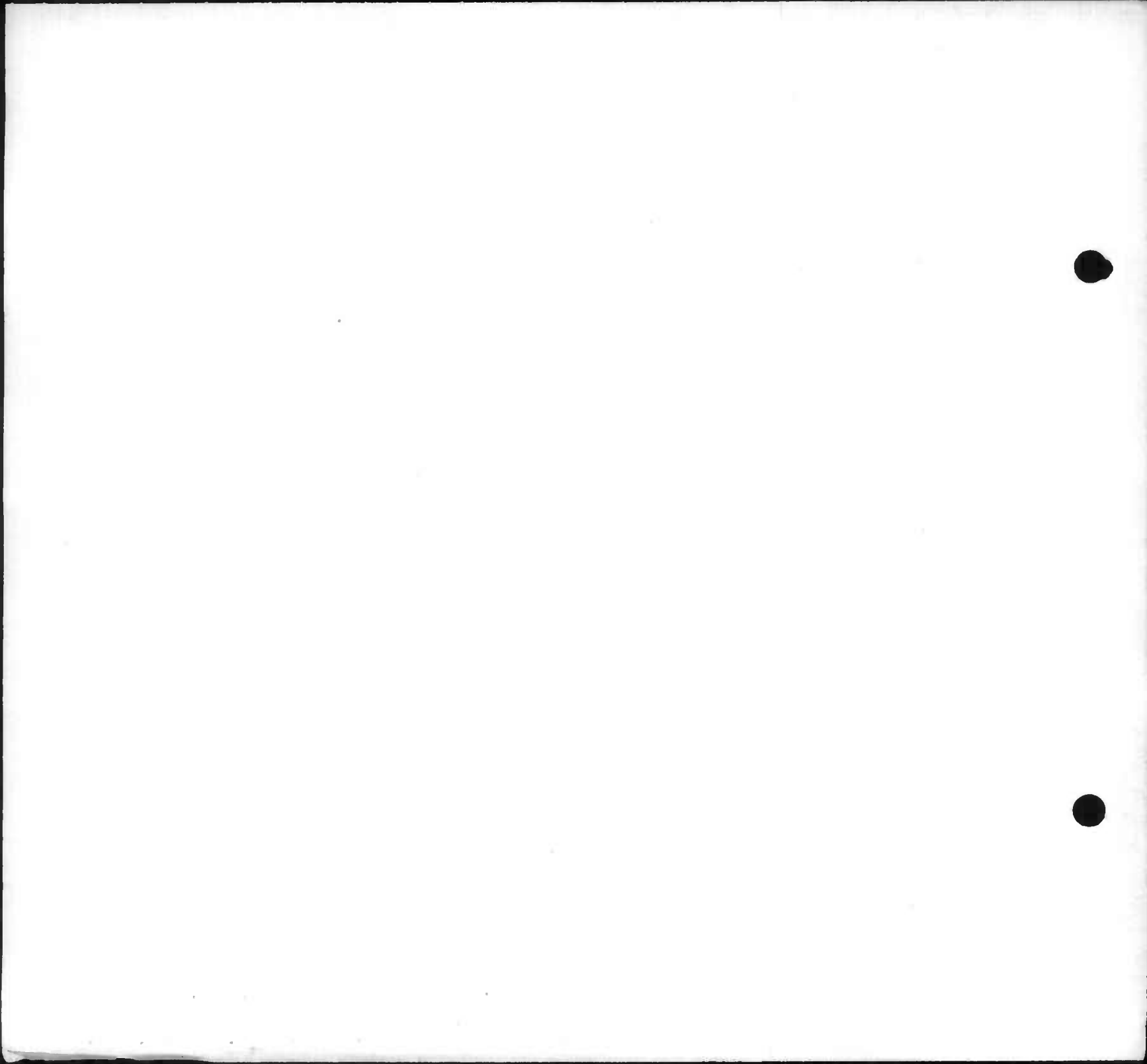
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> T-524 71 8596 BIRTH NO. </div>		<div style="display: flex; justify-content: space-between;"> 71 8596 REG. NO. </div>	
1. NAME OF DECEASED (Type or Print) MELVIN EDWARD TOWNSLEY		2. DATE AND HOUR OF DEATH 9/12/1971 - 11:40AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: Union Memorial Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION: 433RD - CALVERT STREETS BALTO., MD. 21218		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE: MARYLAND B. COUNTY: 908 C. CITY OR TOWN: BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: 2300 HARFORD ROAD	
5. SEX: MALE	6. RACE: White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> XXXX DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH: 9/18/05
9. AGE (In years last birthday): 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heating Engineer	
11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME: Charles E. Townsley		14. MOTHER'S MAIDEN NAME: MARY VIRGINIA DAILEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Unknown		16. SOCIAL SECURITY NO.: 219-01-5357	
17. INFORMANT: Mrs. Wanda Kidwell 22 Lower Gate Ct.		ADDRESS:	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Extensive colon cancer metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION: 9/1/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Colon Cancer	
20A. AUTOPSY? (Yes or No):		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.):	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/20/71 19 71 to 9/12 19 71 that (I) (we) last saw the deceased alive on 9/12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE: 		23B. DATE SIGNED: 9/12/1971	
23C. PHYSICIAN'S NAME (Type): RONALDO DOS SANTOS CARNEIRO		23D. ADDRESS: 33rd & Calvert Sts. Balto MD	
24A. BURIAL CREMATION, REMOVAL (Specify): Burial		24B. DATE: 9/15/71	
24C. NAME of CEMETERY or CREMATORY: Moreland Mem.		24D. LOCATION (City, town, or county) (State): Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.: SEP 14 1971		25B. NAME OF REGISTRAR: Leonard J. Rick Inc.	
25C. FUNERAL DIRECTOR: Leonard J. Rick Inc.		ADDRESS: Balto. Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

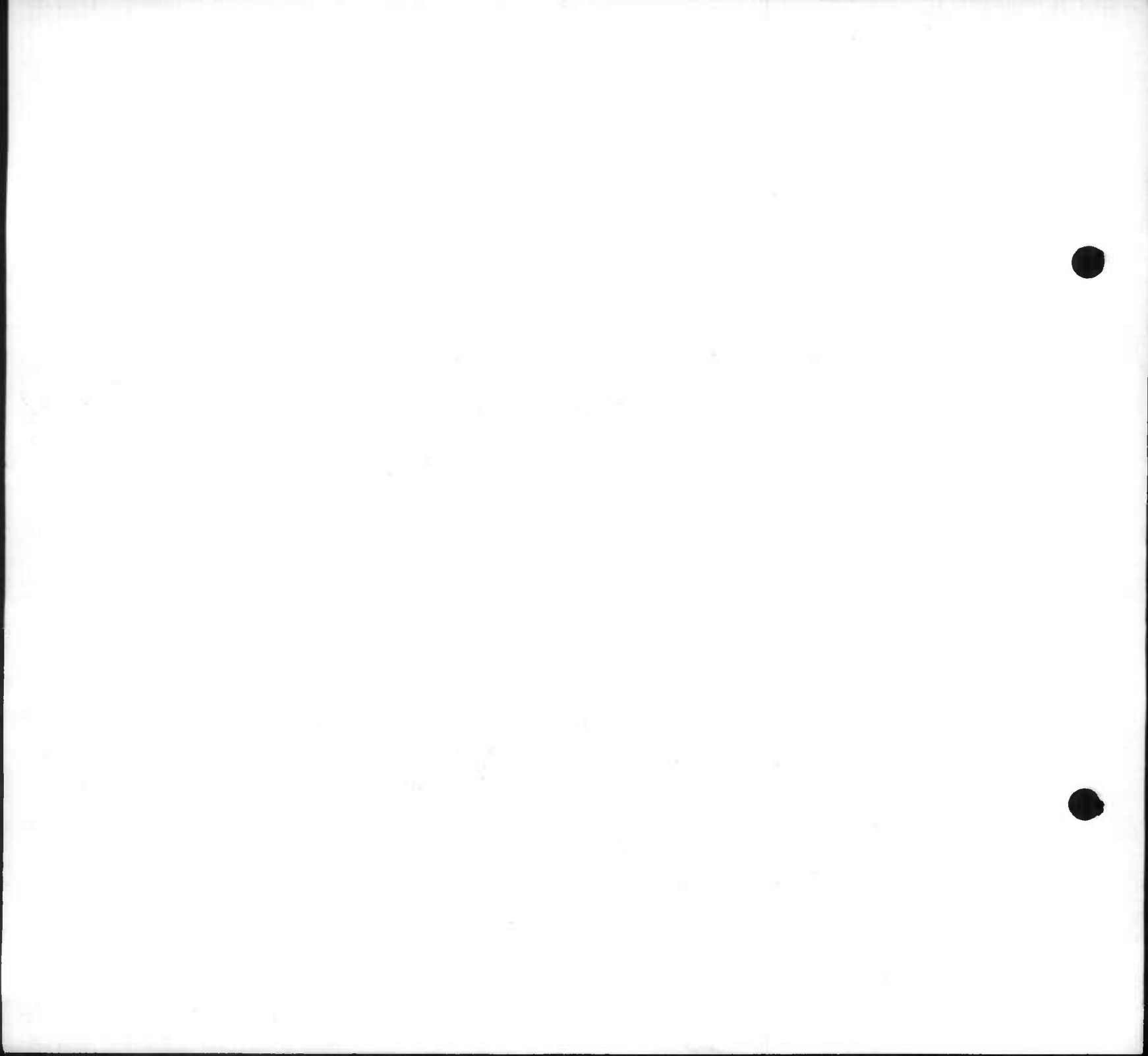
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8597</u>	
<div style="display: flex; justify-content: space-between;"> C-550 71 8597 BIRTH NO. </div>					
1. NAME OF DECEASED (Type or Print) <u>MRS. PEARL L. CANNON</u>			2. DATE AND HOUR OF DEATH <u>9-12-71 10:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL Hosp.</u> <u>48827 LINDEN AVE.</u>			A. STATE <u>MD.</u> B. COUNTY <u>CITY</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4223 HICKORY AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-01</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Langford</u>			14. MOTHER'S MAIDEN NAME <u>xxxxxx</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-09-3856-B</u>	17. INFORMANT <u>(Admission Papers)</u>		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC STANDSTILL</u>			<u>15 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ACUTE CARDIAC DECOMPENSATION</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>WITH CHF</u>		
			(C) <u>ASCVD</u> <u>~ 10 yrs.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>(PROBABLE) ADULT Onset D.M.</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>3-22</u> 19 <u>71</u> to <u>9-12</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-12</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry G. Sacks M.D.</u>			23B. DATE SIGNED <u>9-12-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>HENRY G. SACKS</u>			23D. ADDRESS <u>827 LINDEN AVE., MD. GEN. Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/15/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>North East Meth.</u>	24D. LOCATION (City, town, or county) (State) <u>North East, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Hubert E. Sacks, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Luck Inc. Balto. Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">F-652 71 8598</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		<h2 style="margin: 0;">REG. NO. 71 8598</h2>	
1. NAME OF DECEASED (Type or Print) EDWARD FRANKLIN				2. DATE AND HOUR OF DEATH 9-9-71 0810 HRS.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp. Md.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md B. COUNTY 1901			
5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 03-25-89		9. AGE (in years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT LABORER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO MD	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME SAMUEL FRANKLIN			
14. MOTHER'S MAIDEN NAME A/13A				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 2256-93				17. INFORMANT RAYMOND FRANKLIN, QUEENS N. Y. 11369			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9241X				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 95% whole thickness burn			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 58 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home of victim		21D. TIME OF INJURY (APPROX.) 9-9-71 3 AM	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Burned while spraying insecticide		22. I certify that (I) (this hospital) attended the deceased from 9-9-71 to 9-9-71 and that (I) (we) last saw the deceased alive on 9-9-71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Hector L. Feliciano MD	
23B. DATE SIGNED 9-13-71		23C. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO MD		23D. ADDRESS Univ. Md. Hosp.		23E. FUNERAL DIRECTOR John J. Hayes	
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 9/14/71		24C. NAME OF CEMETERY OR CREMATORY MTAUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR John E. Taylor, A.D.		25C. ADDRESS 125 E. 12th St. Baltimore, Md.		25D. ADDRESS 125 E. 12th St. Baltimore, Md.	

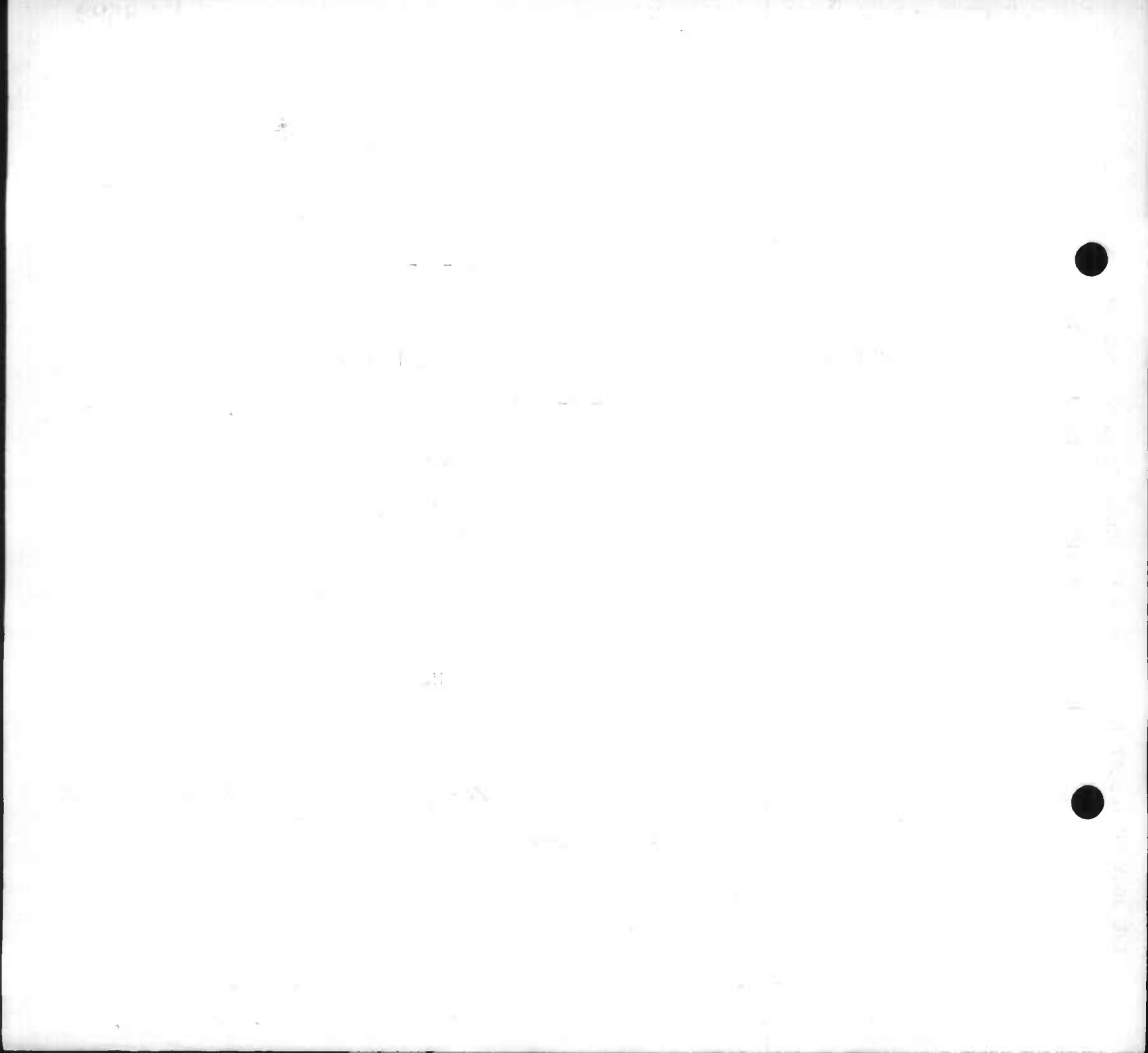


THE BODY OF ROBERT TURNER HAS BEEN RELEASED AS NON MED BY

FUNERAL DIRECTOR: IMPORTANT

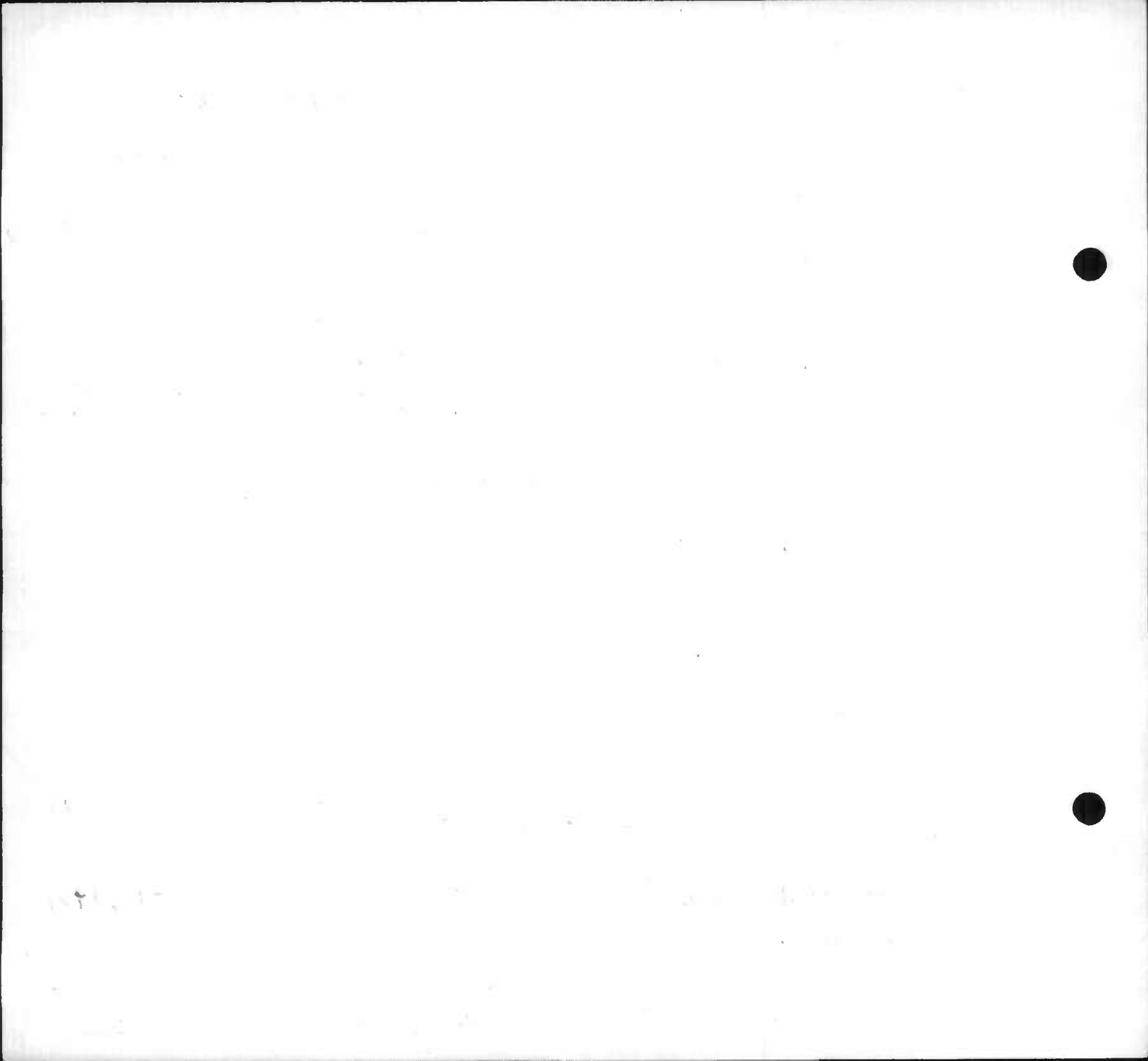
DR SPITZ OF THE MEDICAL EXAMINER'S OFFICE
This certificate must be approved by the chief medical examiner of his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656		71 8599		BALTIMORE CITY HEALTH DEPARTMENT		71 8599	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Robert Turner				2. DATE AND HOUR OF DEATH 9-11-71 7:56 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1002			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital 3601 N. Broadway Baltimore, Md 21205				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-14-20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10B. KIND OF BUSINESS OR INDUSTRY Balto City		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HARVEY TURNER				14. MOTHER'S MAIDEN NAME MOLLIE EDWARDS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 227-12-0461		17. INFORMANT Elaine Turner 2827 E. Chase Street			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest (4%) (B) EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (we) (this hospital) attended the deceased from 9-10-71 to 9-11-71 that (we) last saw the deceased alive on 9-11-71 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. N. Ingle, MD.				23B. DATE SIGNED 9-11-71		23C. PHYSICIAN'S NAME (Type) James N. Ingle, MD.	
23D. ADDRESS The Johns Hopkins Hospital				23E. FUNERAL DIRECTOR Wm C March			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-17-71		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or County) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR 25C. ADDRESS 928 E. North Ave.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8690</u>	
BIRTH NO. <u>S-655 71 8600</u>					
1. NAME OF DECEASED (Type or Print) <u>Dorothy Sherman</u>			2. DATE AND HOUR OF DEATH <u>How 1 A.M. Sept 14, 1971</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4900 Alson Drive</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2834</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4900 Alson Drive</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/01</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Middletown, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Clarence E. Sherman</u>			14. MOTHER'S MAIDEN NAME <u>Minnie R. Sherman</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>068-09-2020</u>	17. INFORMANT <u>St. Petersburg, Fla. ADDRESS 33703</u> <u>Mrs. Edward Kakenmaster, 3918 Helena St. NE.</u>		
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH <u>arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p> </div> <div style="width: 45%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>chronic nephritis</u></p> </div> </div>					
19A. DATE OF OPERATION <u>9/14/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 19 49</u> to <u>Sept 10 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 10 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Kimberly</u>			23B. DATE SIGNED <u>Sept 13, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Robert C. Kimberly</u>			23D. ADDRESS <u>103 East Chase Street 21202</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/14/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Edgartown, Mass.</u>	
24D. LOCATION <u>Edgartown, Mass.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert C. Kimberly</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue 21228</u>	

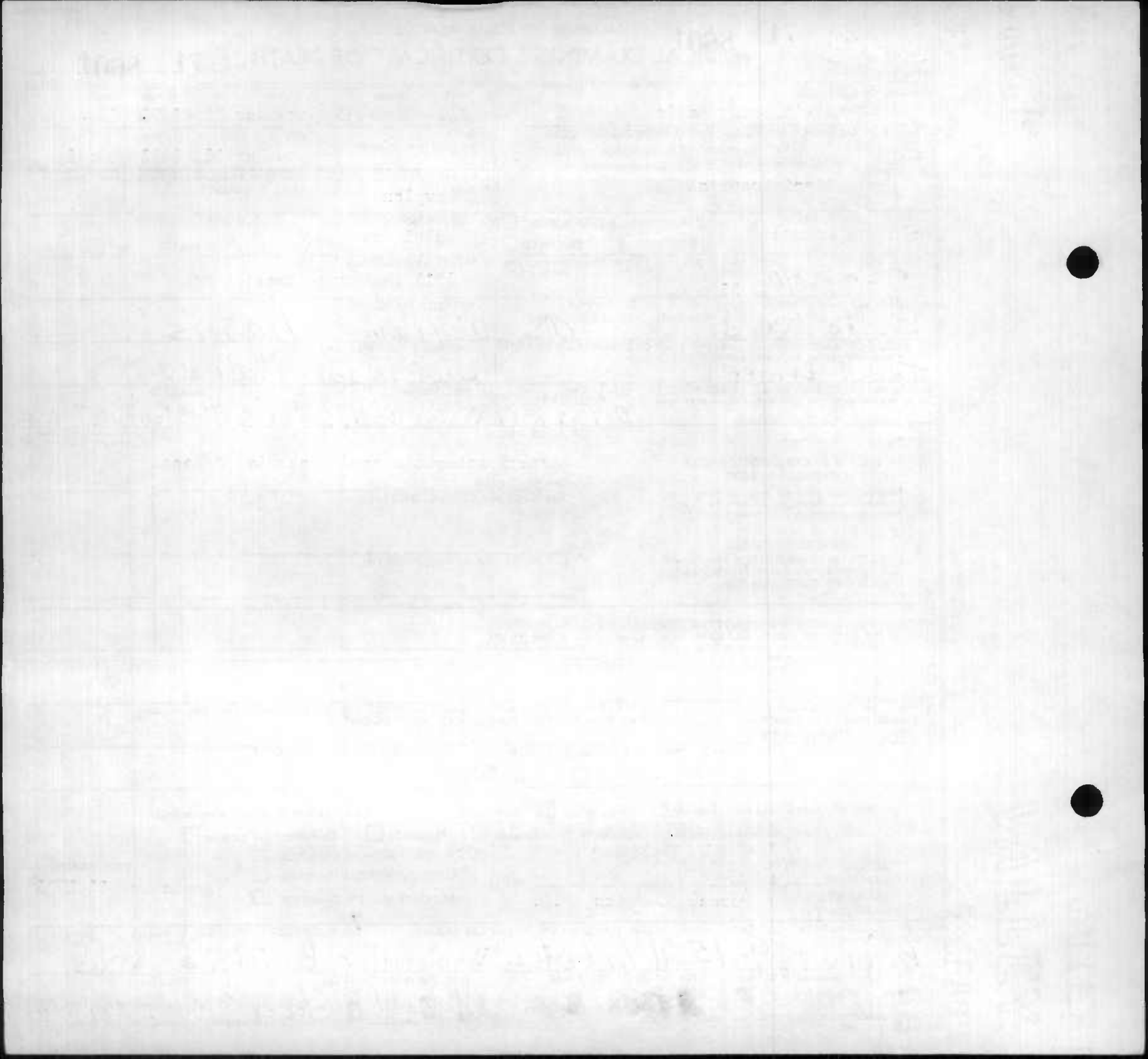


BIRTH NO. D-120 71 8601 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 8601

8601 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71-8601

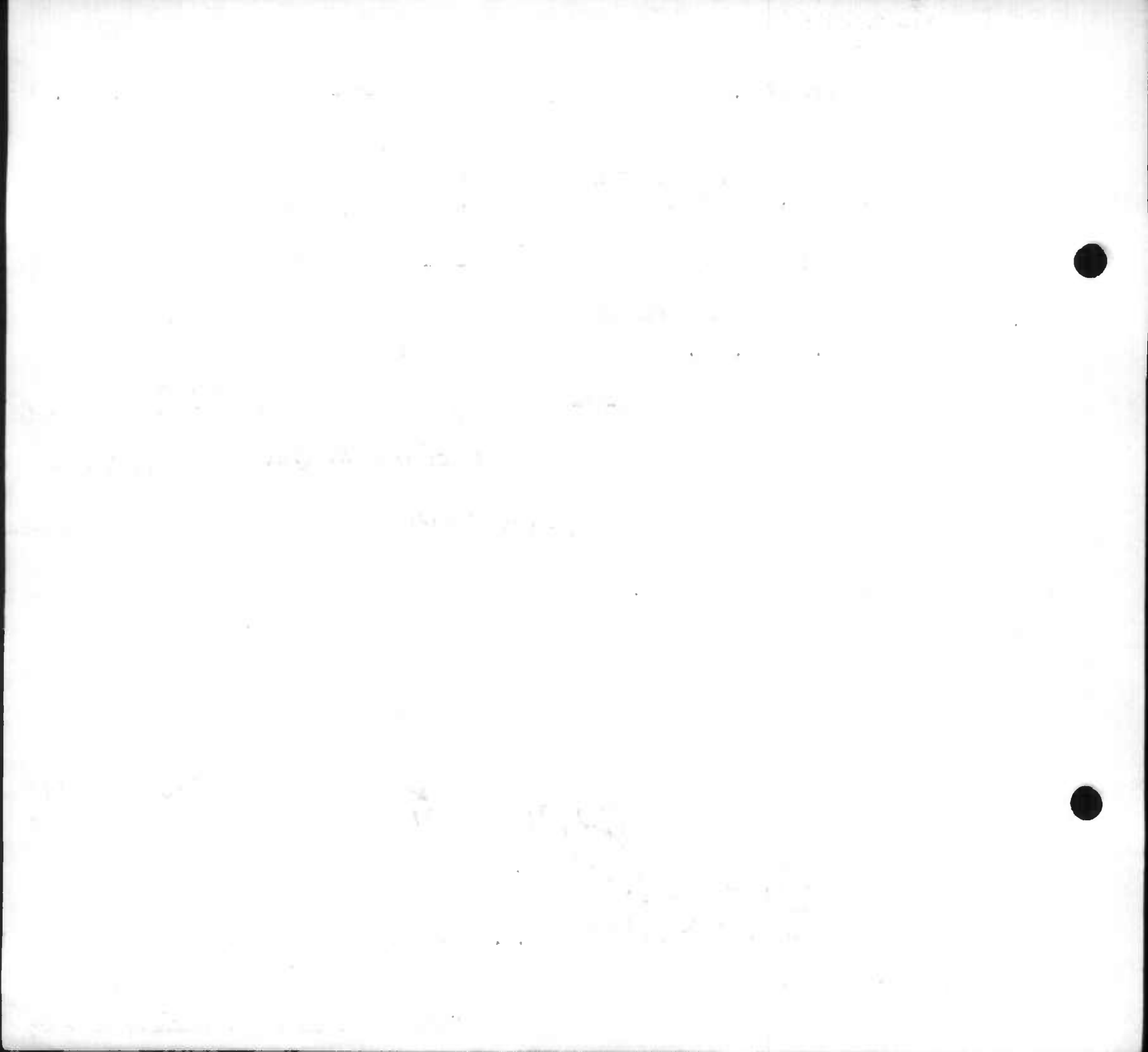
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Alvin Carey Davis		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 11, 1971 12:00 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 11, 1971 00:01 AM	
6. SEX Male		7. RACE Colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-21-40		10. AGE (In years last birthday) 31	
11. BIRTHPLACE (State or foreign country) Balto Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Davis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
15. MOTHER'S MAIDEN NAME Lucinda Carey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 214-64-1387		18. INFORMANT Marcellus Carey	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obesity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9-12-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 11, 1971		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9-15-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971	
25B. NAME OF REGISTRAR Donald E. Glover		25C. FUNERAL DIRECTOR 712-14 E North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8602	
BIRTH NO. 71 8602		1. NAME OF DECEASED (Type or Print) AUGUST A. BAKER			
2. DATE AND HOUR OF DEATH 09-12-71 4:25 P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE CALIFORNIA B. COUNTY BERKELEY		5. CITY OR TOWN BERKELEY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5 1/2 PANORAMIC WAY			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-19	9. AGE (in years last birthday) 51	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junior		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Mt. Carmel, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME AUGUST A. BAKER, SR.		14. MOTHER'S MAIDEN NAME EFFIE COZINE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. II		16. SOCIAL SECURITY NO. 356-10-8452		17. INFORMANT Dr. Gilbert Butler, Surgeon, M.D.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ESOPHAGEAL ULCER ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HEPATOMA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH UNDETERMINED	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/12/71 to 9/12/71 that (I) (we) last saw the deceased alive on 9/12/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Page T.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) STEPHEN PAGE T.	
23D. ADDRESS		24A. BUNAL CREMATION, REMOVAL (Specify) Funeral			
24B. DATE SEP 15, 1971		24C. NAME OF CEMETERY or CREMATORY Adams Corner Cemetery		24D. LOCATION (City, town, or county) (State) Alhambra, Ill.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Feltz, M.D.		25C. FUNERAL DIRECTOR Frank H. Newell, Piquetteville 8, Mo.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 8603

BIRTH NO. 71 8603

1. NAME OF DECEASED
(Type or Print)

WALL, MAMIE

2. DATE AND HOUR OF DEATH

Sept. 10, 1971

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

805

C. CITY OR TOWN

BALTIMORE,

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1728 NORMAN AVE

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

02/09/16

9. AGE (In years
last birthday)

55

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Government

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Augustus Coles

14. MOTHER'S MAIDEN NAME

ALICE COLE

15. Was Deceased Ever In U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

James Wall, 1728 Norman Ave

18. 25091

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

uremia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

diabetes, hypertension

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

1 (Month) 2 (Day) 3 (Year) 4 (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 1 19 71 to Sept. 10 19 71
that (I) (we) last saw the deceased alive on Sept. 10 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Penelope P. Scott

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

PENELOPE P. SCOTT M.D.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

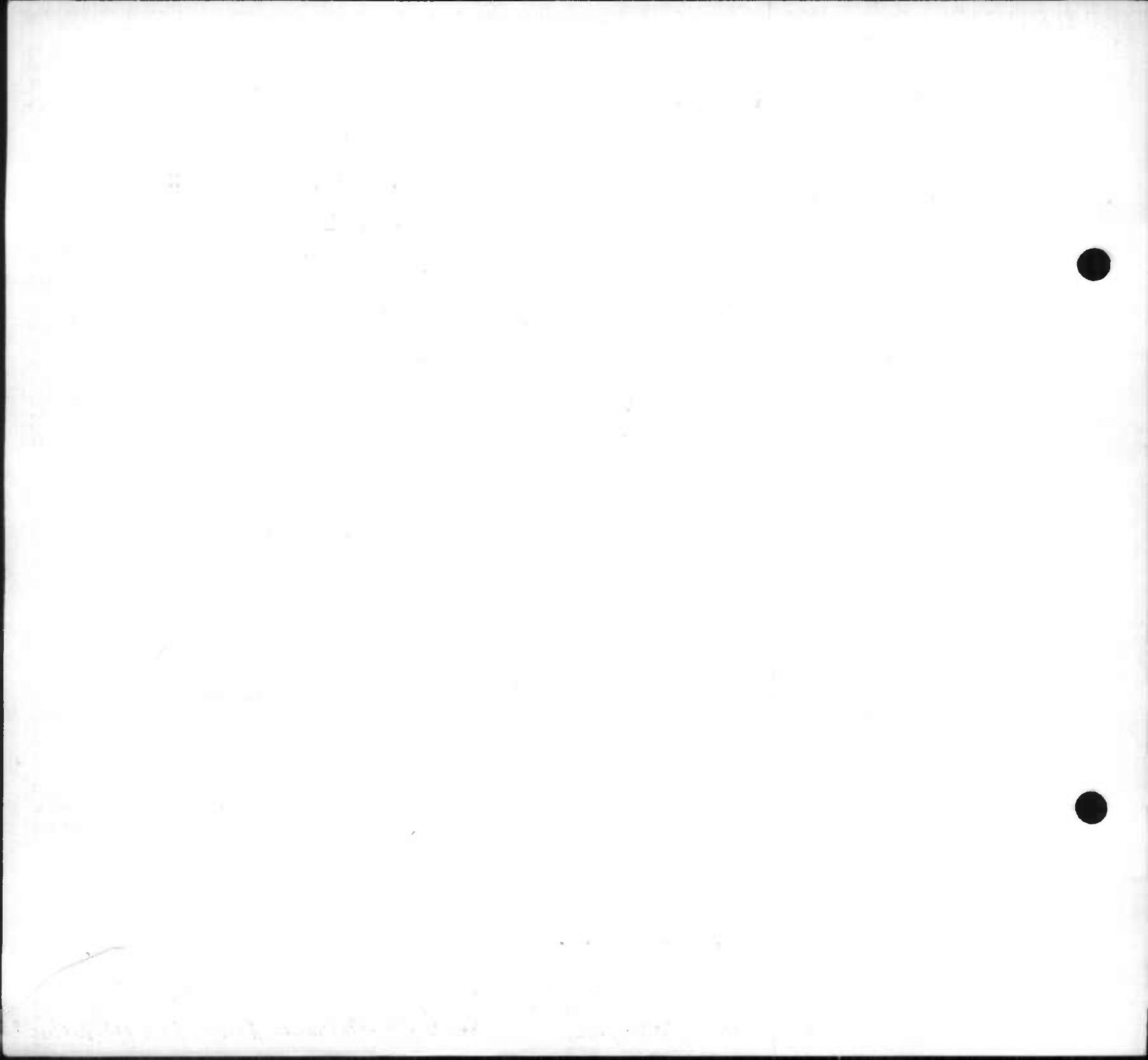
25C. FUNERAL DIRECTOR

ADDRESS

SEP 14 1971

Robert E. Taylor, Jr.

Robert E. Taylor, Jr. 1129 N. Calver St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8604

BIRTH NO. 71 8604

1. NAME OF DECEASED
(Type or Print)

IVA RANDALL

2. DATE AND HOUR OF DEATH

9/12/71

3:36 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Provident Hospital Complex
2600 Liberty Heights
Baltimore, Maryland 212154. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

519 Bloom Street

5. SEX

Female

6. RACE

Black

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7-25-92

9. AGE (in years
last birthday)

79

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James O. Carter

14. MOTHER'S MAIDEN NAME

Sarah Taylor

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
212-05-0534

17. INFORMANT

Mr. William Randall (Son)

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 days - 2 weeks

years

UNKNOWN

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/12 1971 to 9/12 1971
that (I) (we) last saw the deceased alive on 9/12 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Elijah Saunders

DEGREE

Attending ☒ Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9/13/71

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-16-71

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 14 1971

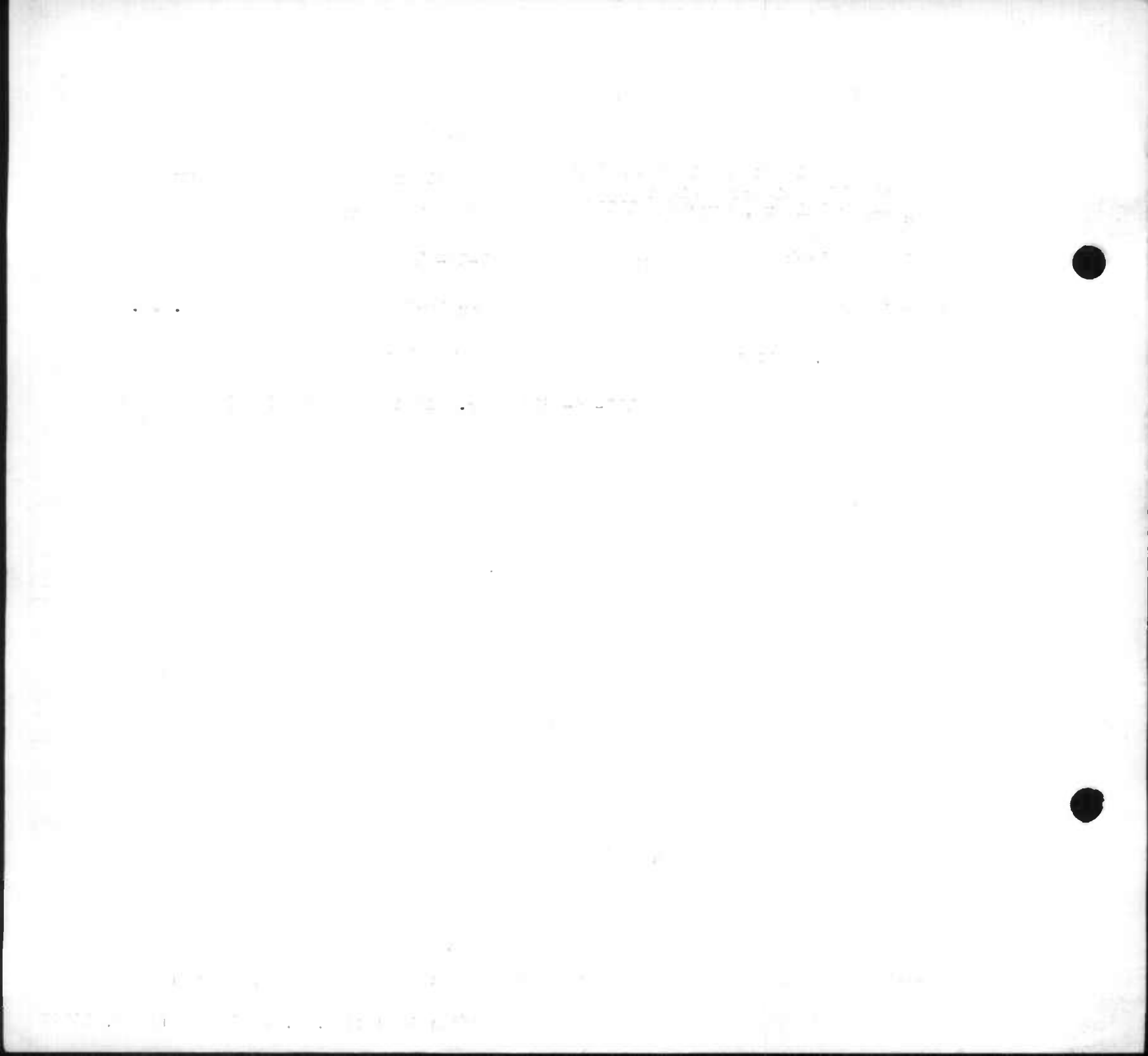
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Morton & Dyett F. H. 1701 Laurens St. 21217

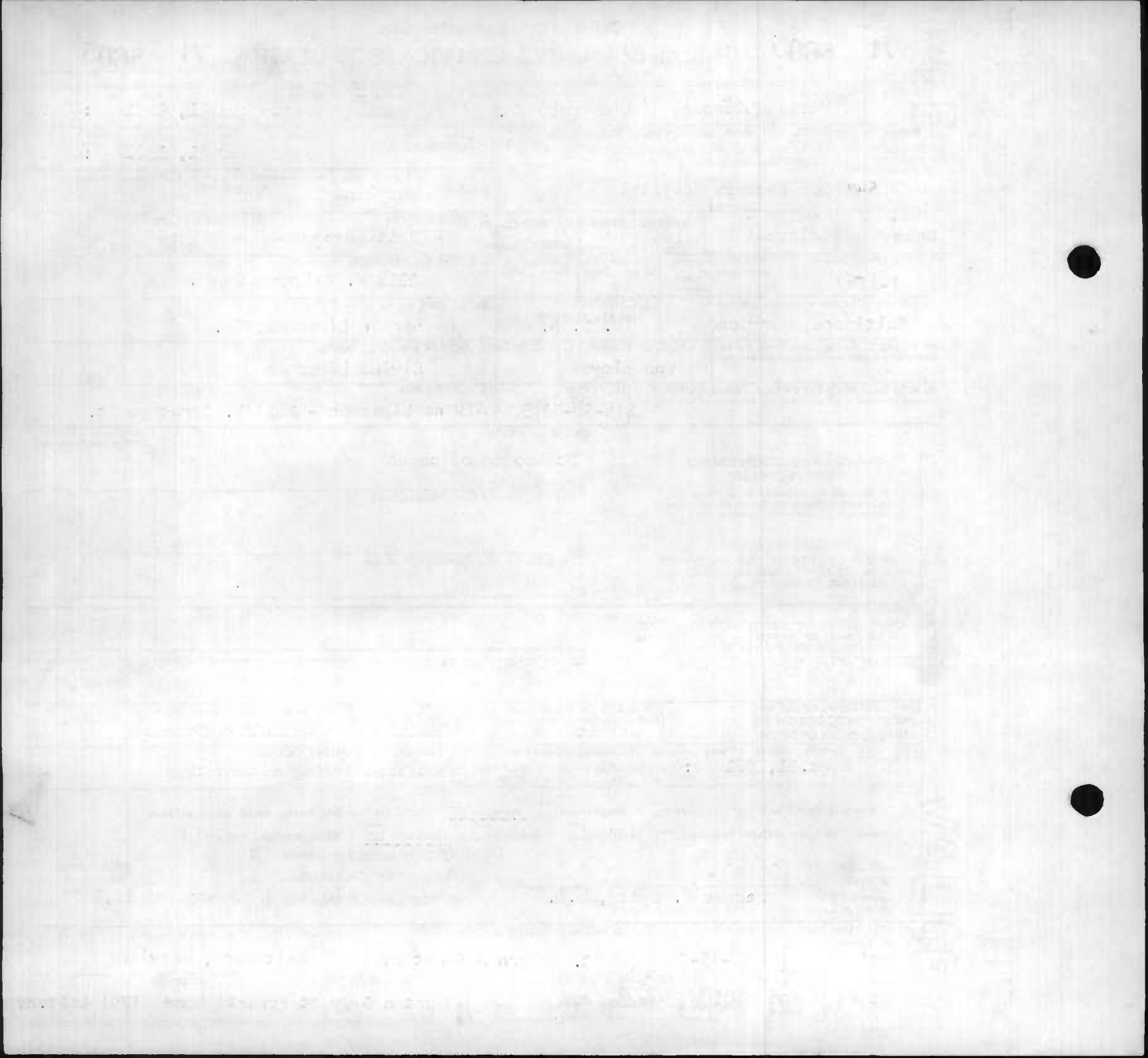


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Herman Lipscomb (Lipscomb) Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 11, 1971 Hour 6:40 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 11, 1971 Hour 6:40 PM	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2002	
9. DATE OF BIRTH 1-17-49		10. AGE (In years last birthday) 22	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Alvina Lipscomb	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-50-3309	
18. INFORMANT Alvina Lipscomb - 2021 W. Saratoga St.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Stabwound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Baltimore & Carrollton Streets 1802		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Sept. 11, 1971 4:00 PM	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? stabbed during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 12, 1971 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-15-71	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Home		ADDRESS 1701 LaStens	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8606

BIRTH NO. 71 8606

1. NAME OF DECEASED
(Type or Print)

BALDWIN, Charles

2. DATE AND HOUR OF DEATH

9/11/71

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

2542 West Fairmount Ave.
Balto., Md. 21223

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2542 W. Fairmount Ave.

5. SEX

Male

6. RACE

Negroid

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/19/12

9. AGE (In years
last birthday)

58

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Holly Spring, N. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Cleveland Baldwin

14. MOTHER'S MAIDEN NAME

Nina Mae Young

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1945-46

16. SOCIAL
SECURITY NO.

17. INFORMANT

Novella Baldwin

ADDRESS

SAME

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 mo.

10 yrs

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 19 71 to Sept. 19 71
that (we) last saw the deceased alive on June 26 19 71 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Louis E. Denny M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

9/14/71

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

11 East Chase St. Balto. Md. 21202

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/14/71

24C. NAME OF CEMETERY OR CREMATORY

Carver Memorial Park

24D. LOCATION

Laurel, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 14 1971

25B. NAME OF REGISTRAR

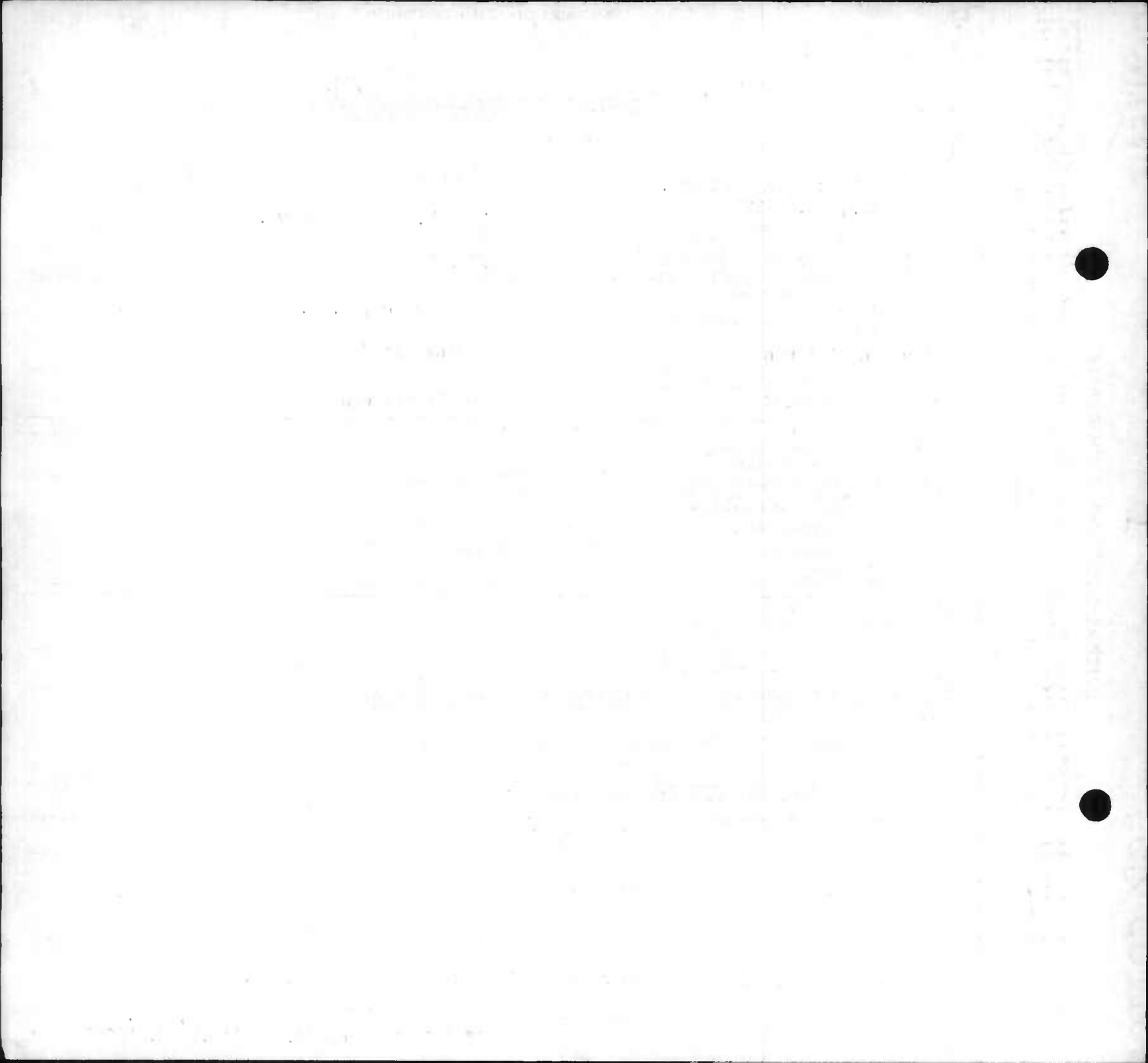
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOMES, INC.

ADDRESS

1701-31 Laurens St., Balto., Md. 21217

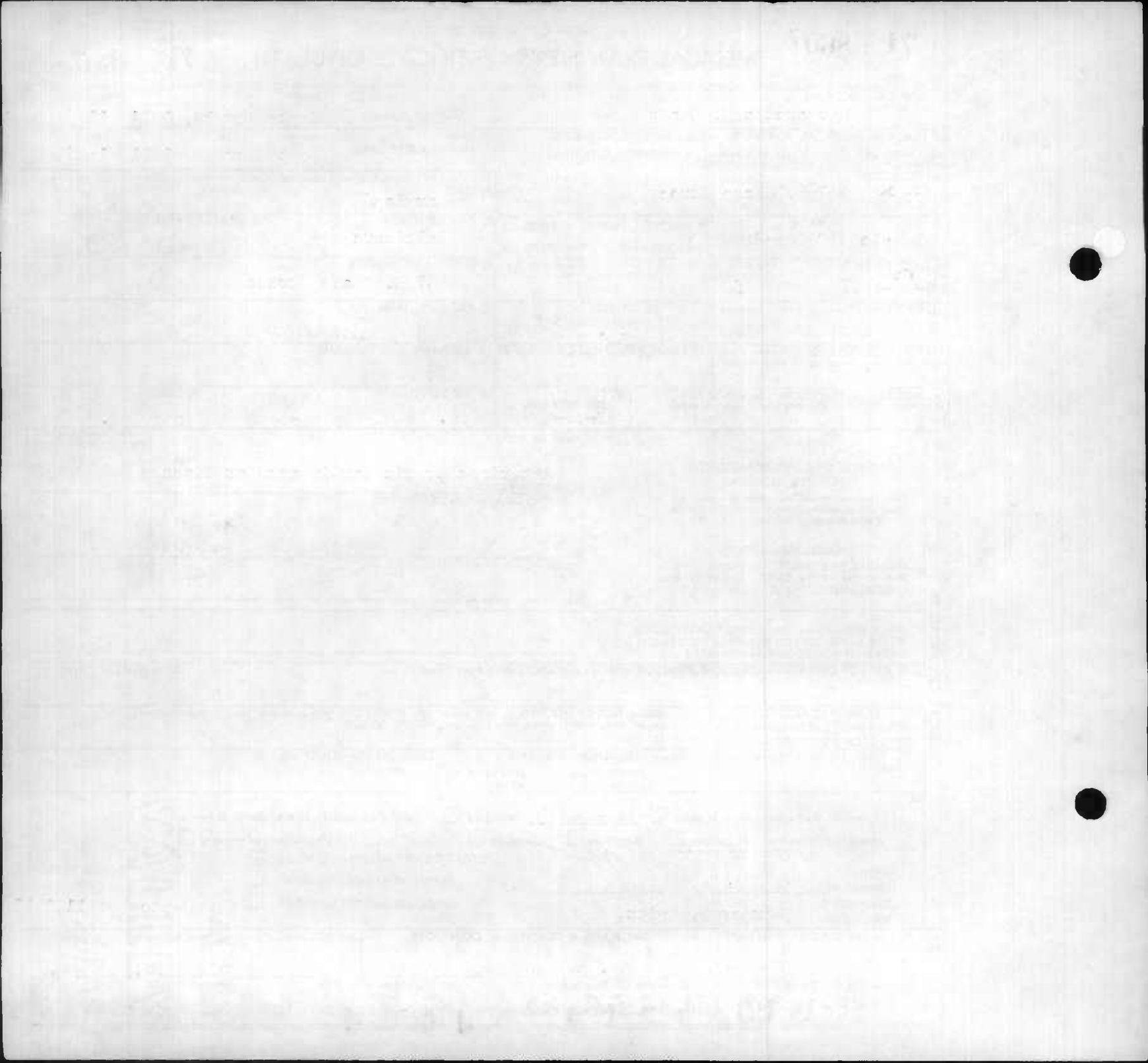


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaretta E. Evans		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 10, 1971 11:50 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 947 E. Chase Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 11, 1971 1:05 AM	
6. SEX Female		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1001	
9. DATE OF BIRTH 4-14-1921		10. AGE (In years lost birthday) 50	
11. BIRTHPLACE (State or foreign country) Vera Cruz, New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SWARTZ		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Rosie Lewis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-16-4894		18. INFORMANT ADDRESS Mrs. Naomi-Taylor-3222 Westmont Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-15-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mary-Elizabeth Law		25D. ADDRESS 802 Madison Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

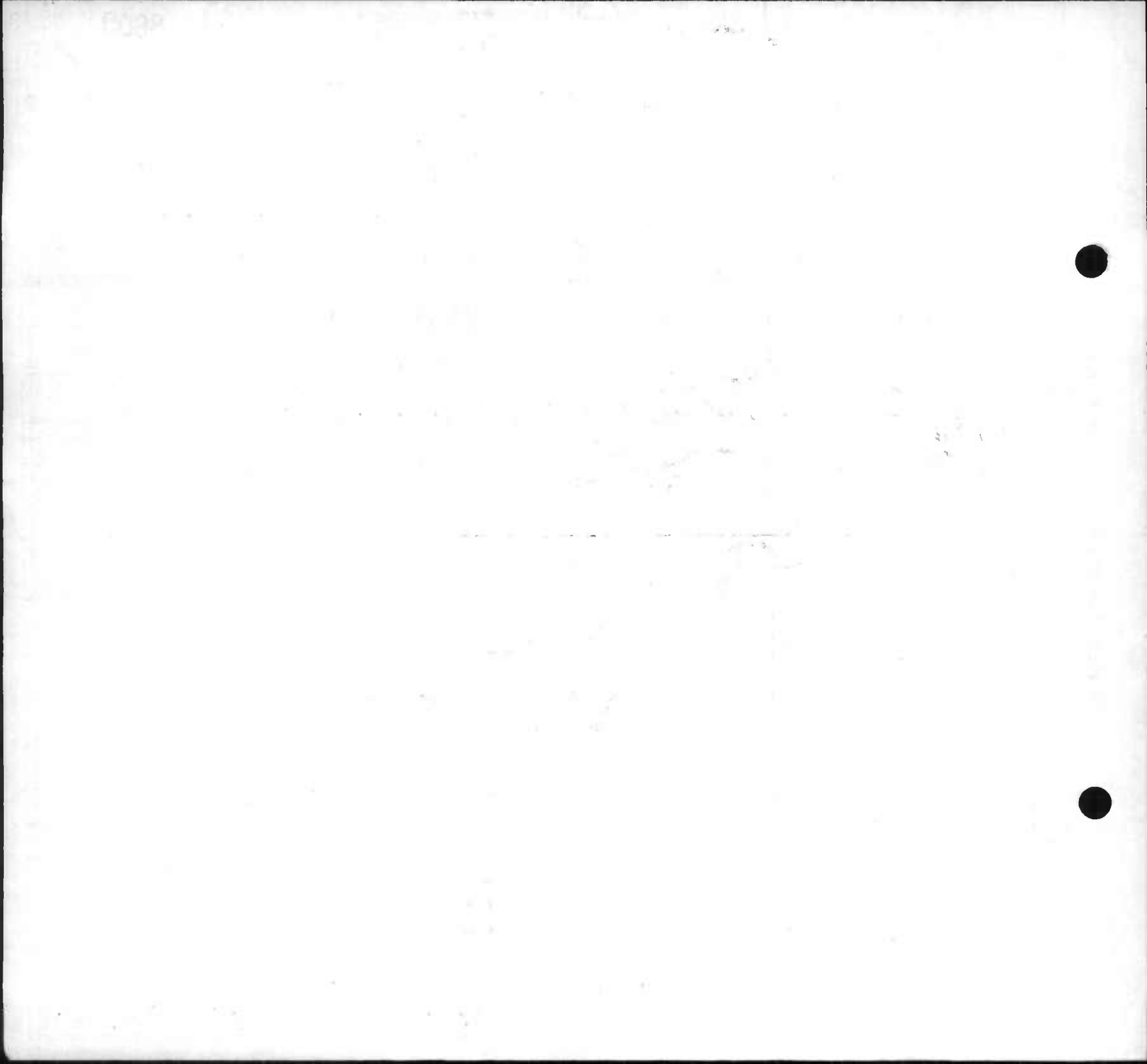
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8608</u>	
<div style="display: flex; justify-content: space-between;"> K-460 71 8608 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Adam A. Keller			2. DATE AND HOUR OF DEATH 9-12-71 10:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE Md.		B. COUNTY
IF NOT IN HOSPITAL OR (INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3900 N. Charles St.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3900 N. Charles St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-89	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10B. KIND OF BUSINESS OR INDUSTRY Grain	11. BIRTHPLACE (State or foreign country) Owensboro, Ky.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adam Keller			14. MOTHER'S MAIDEN NAME Fannie Chrissman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-5039	17. INFORMANT Mrs. Adam A. Keller		ADDRESS Same
18. CAUSE OF DEATH					
(A) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Antenatal - e.v.d.s</i>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/11 to 9/12 1971 that (1) (we) last saw the deceased alive on 9/11 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Charles E. Carr, Jr.</i>				23B. DATE SIGNED 9/13/71	
23C. PHYSICIAN'S NAME (Type) Dr. Charles E. Carr, Jr.				23D. ADDRESS 3900 N. Charles St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71		24C. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Owensboro Kentucky	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	

1871-72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

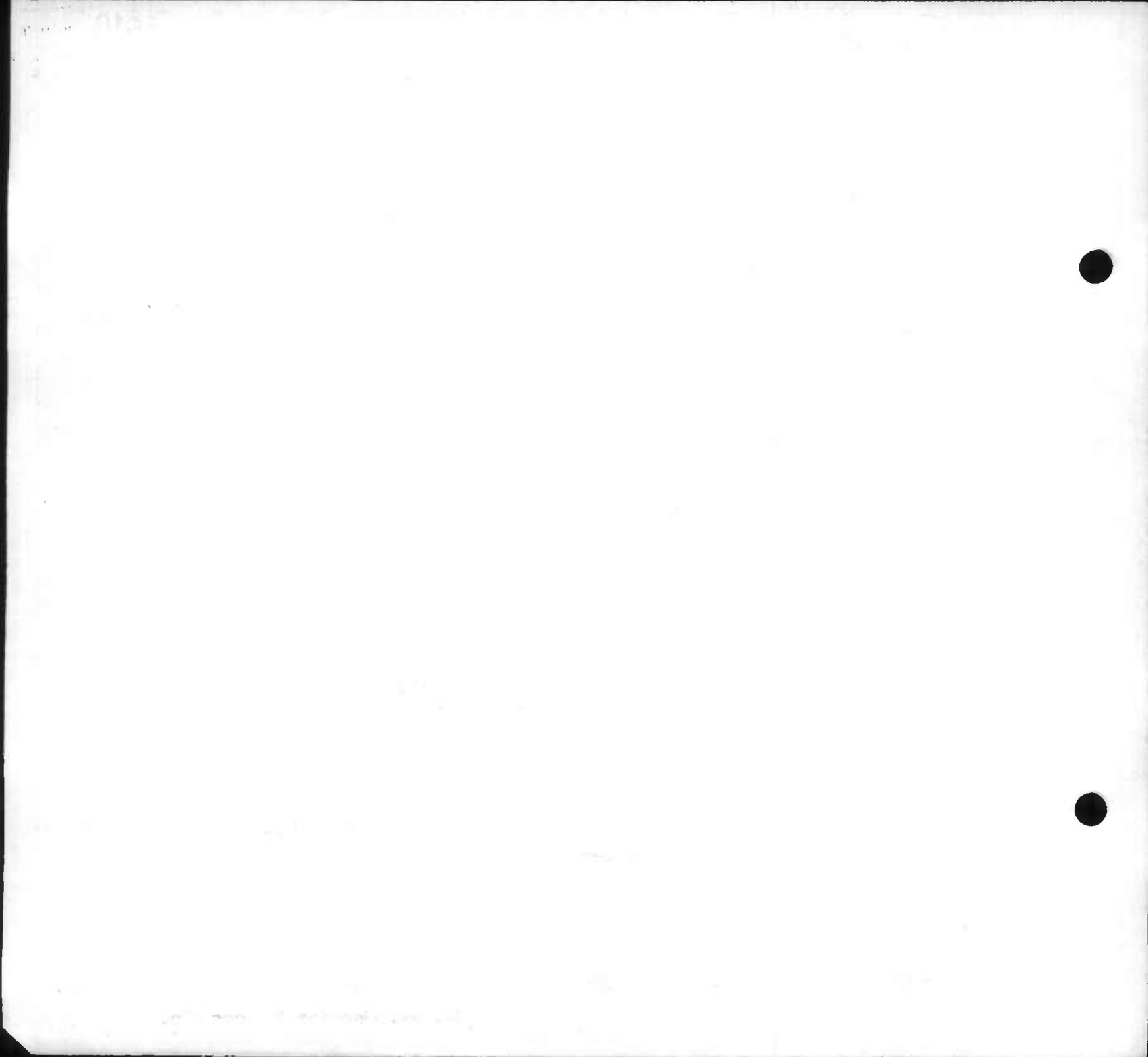
BALTIMORE CITY HEALTH DEPARTMENT				71 8609	
E-635 71 8609				REG. NO. 71 8609	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John Ernest Erdman, Jr.			2. DATE AND HOUR OF DEATH 9-11-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4315 Marble Hall Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2759		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4315 Marble Hall Rd. Apt. 155		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-90	9. AGE (in years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Auto Sales		10B. KIND OF BUSINESS OR INDUSTRY Mercedes Benz		11. BIRTHPLACE (State or foreign country) Lexington, Kentucky	
13. FATHER'S NAME John Ernest Erdman			14. MOTHER'S MAIDEN NAME Elizabeth Kenney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 212-10-6959		17. INFORMANT Mrs. J. E. Erdman	
				ADDRESS Same	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA-LUNG 5 MONTHS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 5, 1971 to SEPT. 11, 1971 that (I) (we) last saw the deceased alive on SEPT. 10, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur Karfgin M.D.				23B. DATE SIGNED 9/13/71	
23C. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin				23D. ADDRESS 1532 Havenwood Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Holly Cemetery	
				24D. LOCATION (City, town, or county) (State) Mt. Holly, New Jersey	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

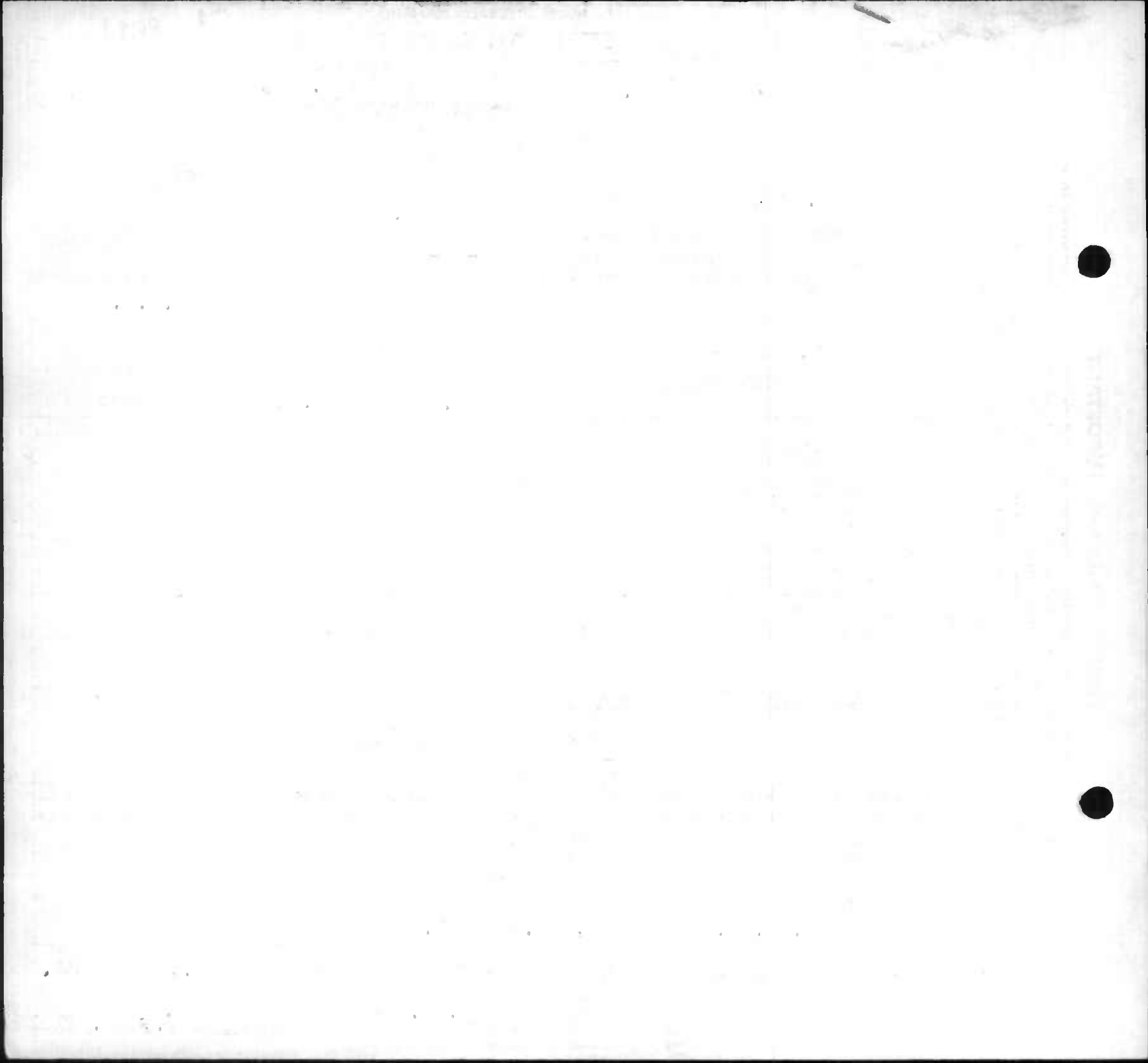
BALTIMORE CITY HEALTH DEPARTMENT		71 8610	
S-314 71 8610		REG. NO. 71 8610	
BIRTH NO.		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) ARTHUR G. STAVELY		2. DATE AND HOUR OF DEATH 9-12-71 6:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 906	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1704 E 32nd St.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Stavelly		14. MOTHER'S MAIDEN NAME Mary H. Hodges	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 212-09-0615	
17. INFORMANT Mary Stavelly		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Auto myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Cumulative Heart Disease	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-7-71 to 9-12-71 and that (I) (we) last saw the deceased alive on 9-12-71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE MA. ELENA V. MANGAY		23B. DATE SIGNED 9-12-71	
23C. PHYSICIAN'S NAME (Type) MA. ELENA V. MANGAY		23D. ADDRESS Church Home + Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71	
24C. NAME OF CEMETERY or CREMATORY Washington Cemetery		24D. LOCATION (City, town, or county) (State) Hurlock, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Jenkins, Jr.	
25C. FUNERAL DIRECTOR H. H. Jenkins & Sons Co.		ADDRESS 4906 York Road Balto.; Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8611	
A-330 71 8611				REG. NO. 71 8611	
BIRTH				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Mrs. Jeannie L. Atwood				Sept. 12, 1971 3:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 309 E. Cold Spring Lane				Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-25-1898 9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. Talbott				14. MOTHER'S MAIDEN NAME Lella Ammons	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Charles B. Atwood ADDRESS Same	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from May 19 52 to 7/12 1971 that (I) (we) last saw the deceased alive on 7/10 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE W. H. Townshend, Jr. DEGREE 23B. DATE SIGNED 9/13/71 23C. PHYSICIAN'S NAME (Type) Dr. W. H. Townshend, Jr. 23D. ADDRESS 14 E. Eager Street 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9-15-71 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park 24D. LOCATION Baltimore Co., Md. 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 1905 York Road Balto., Md. 21212					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8612	
W-352 71 8612				CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>WHITING, DELORES</u>		2. DATE AND HOUR OF DEATH <u>9-12-71</u> <u>4:15</u> <u>A</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u> <u>34</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2001</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>312 N. MONROE</u>			
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-35</u>		9. AGE (In years lost birthday) <u>36</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>MINNIE PASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>N. Flores Low</u> ADDRESS	
18. I <u>161.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration pneumonia & abscess</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Larynx by Hx</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>treated & irradiation</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> <u>2 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>72</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-11-1971</u> to <u>9-12-1971</u> that (I) (we) last saw the deceased alive on <u>9-12-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marco Flores MD</u> DEGREE		23B. DATE SIGNED <u>9-12-71</u>		23C. PHYSICIAN'S NAME (Type) <u>MARCO FLORES</u> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-16-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>W. G. H. S. F. M.</u> ADDRESS <u>1532 Hollins</u>			



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LINDA ROSS (RORRIS)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 13 1971 2 a M.	
6. SEX female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 806	
7. RACE negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9.15.1948	10. AGE (In years last birthday) 23	E. STREET AND NUMBER 1624 N. Washington St.	
11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Leonard H. Harris	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Sarah Bell Nichols	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO. 215-46-9510	18. INFORMANT ADDRESS Sister 1624 N. Washington St.	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Gunshot wounds of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 3836 Park Heights Ave.		22F. HOW DID INJURY OCCUR? Shot by husband.	
22D. TIME OF INJURY (APPROX.) 8-26-71 2:55 pm.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 9/13/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9.17.71	24C. NAME OF CEMETERY or CREMATORY Int. Auburn	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971	25B. NAME OF REGISTRAR Patricia E. Gentry	25C. FUNERAL DIRECTOR ADDRESS Linda D. Caudle Balto. Md.	

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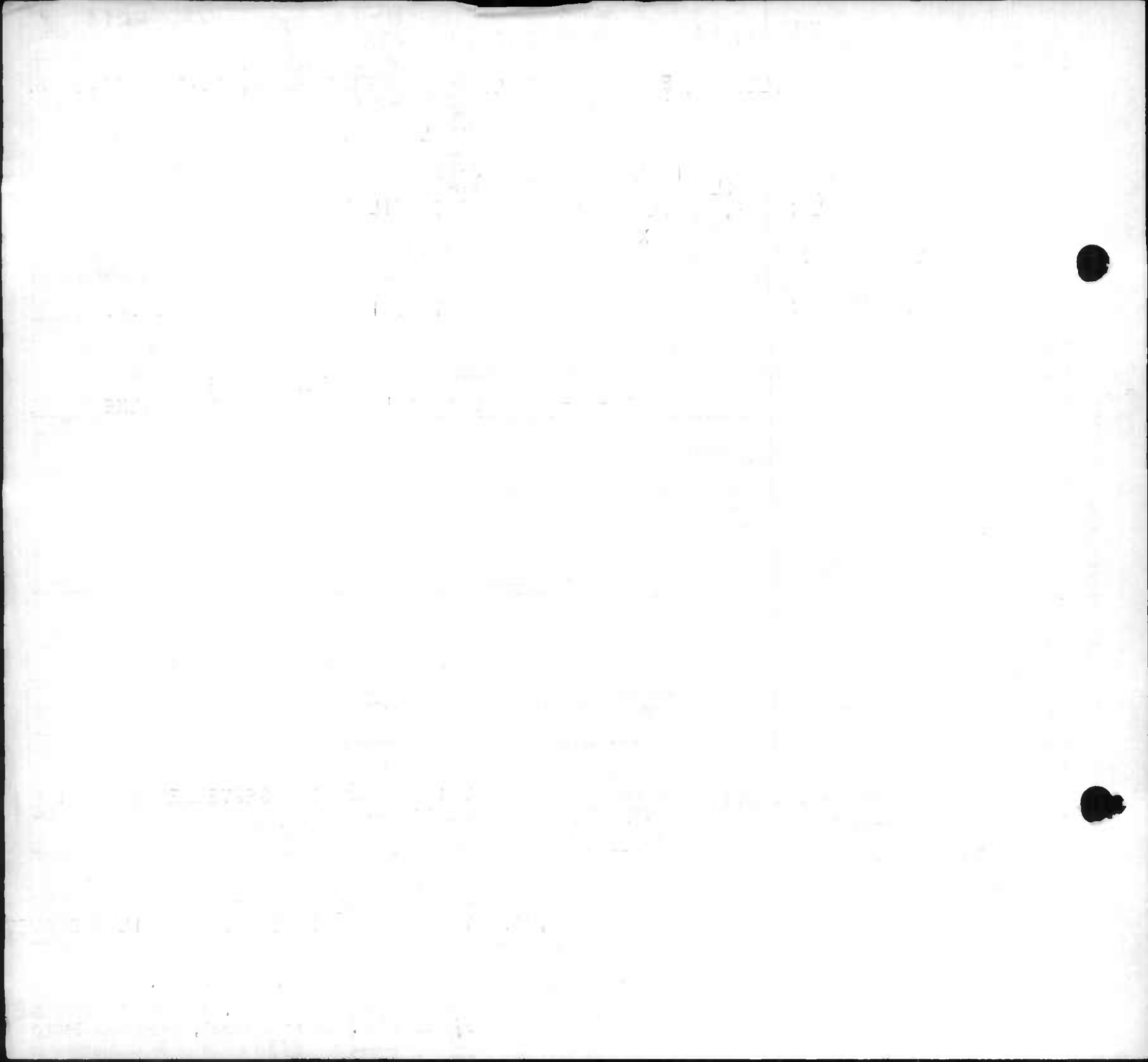
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

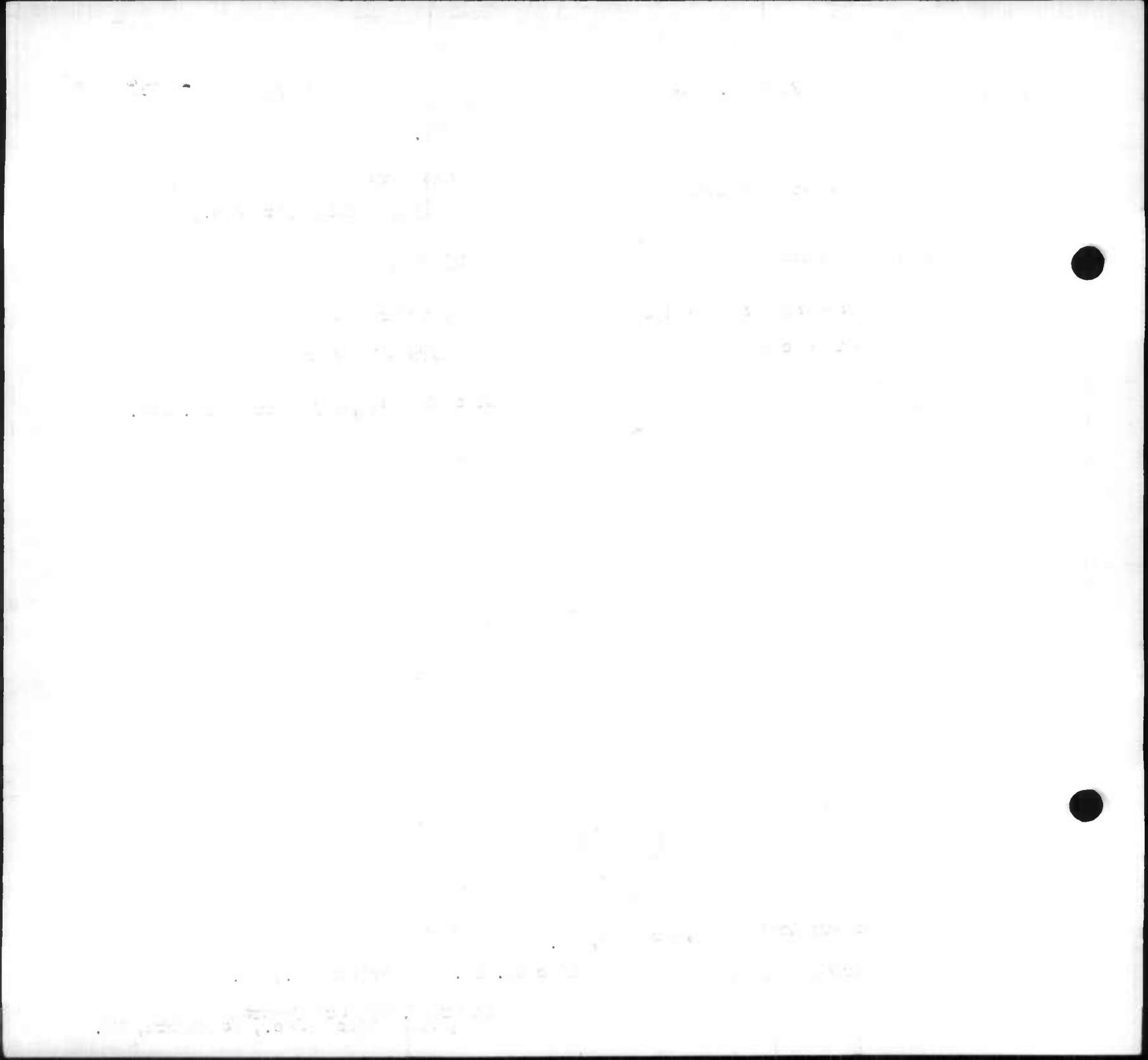
W-452 71 8614		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8614	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) WILLIAMS, EASON ROOSEVELT			2. DATE AND HOUR OF DEATH SEPTEMBER 9, 1971 11:00 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN JESSUP D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 9547 GUILFORD ROAD					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/28/05	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Williams		14. MOTHER'S MAIDEN NAME Laura North	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-7975		17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Metastatic CA of the Breast DUE TO, OR AS A CONSEQUENCE OF: CA of the Lungs (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 18 1971 to SEPTEMBER 9 1971 that (X) (we) last saw the deceased alive on SEPTEMBER 9 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Nich Stratigakos				23B. DATE SIGNED 9-9-71	
23C. PHYSICIAN'S NAME (Type) NICH. STRATIGAKOS, MD.				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY OR CREMATORY Savage Cemetery	
24D. LOCATION Savage, Howard Co., Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Jolley, M.D.		25C. FUNERAL DIRECTOR Laurel Funeral Home Inc. 550 Washington Blvd. of Howard M. Fleck Laurel, Maryland 20810	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

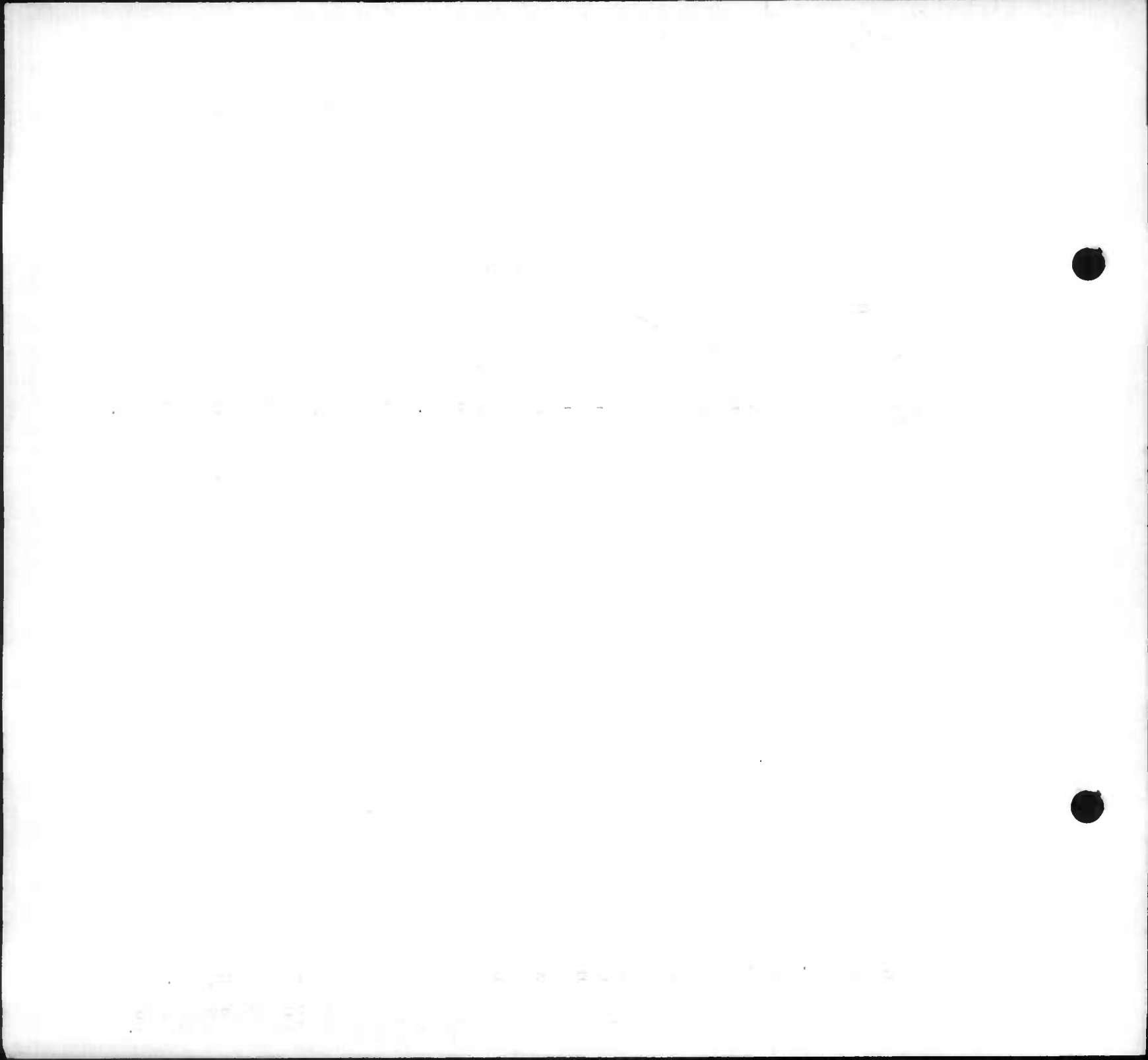
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8615	
0-520 71 8615				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANK M. OWENS		9/10/71 4:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION St Agnes Hospital			A. STATE Md.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1712 Morrell Park Ave.,		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/01	9. AGE (in years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Salesman		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Howard Owens			14. MOTHER'S MAIDEN NAME Etta Sinclair		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ethel I Owens, 1712 Morrell Pk. Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Recurrent Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF: Thrombosis (B) Arteriosclerotic CVD, advanced DUE TO, OR AS A CONSEQUENCE OF: (C) _____ Diabetes mellitus		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/12/71 to 9/10/71 that (1) (we) last saw the deceased alive on 8/12/71 and that (1) (my) (our) apptn death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert Levickas			23B. DATE SIGNED 9/11/71		
23C. PHYSICIAN'S NAME (Type) Herbert Levickas			23D. ADDRESS 5404 East Drive Baltimore, Md. 21227		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY or CREMATORY Meadow Ridge Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Howard Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR R. G. J. J. J.		25C. FUNERAL DIRECTOR Howard H. Hubbard Funeral Home 4107 Wilkens Ave., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

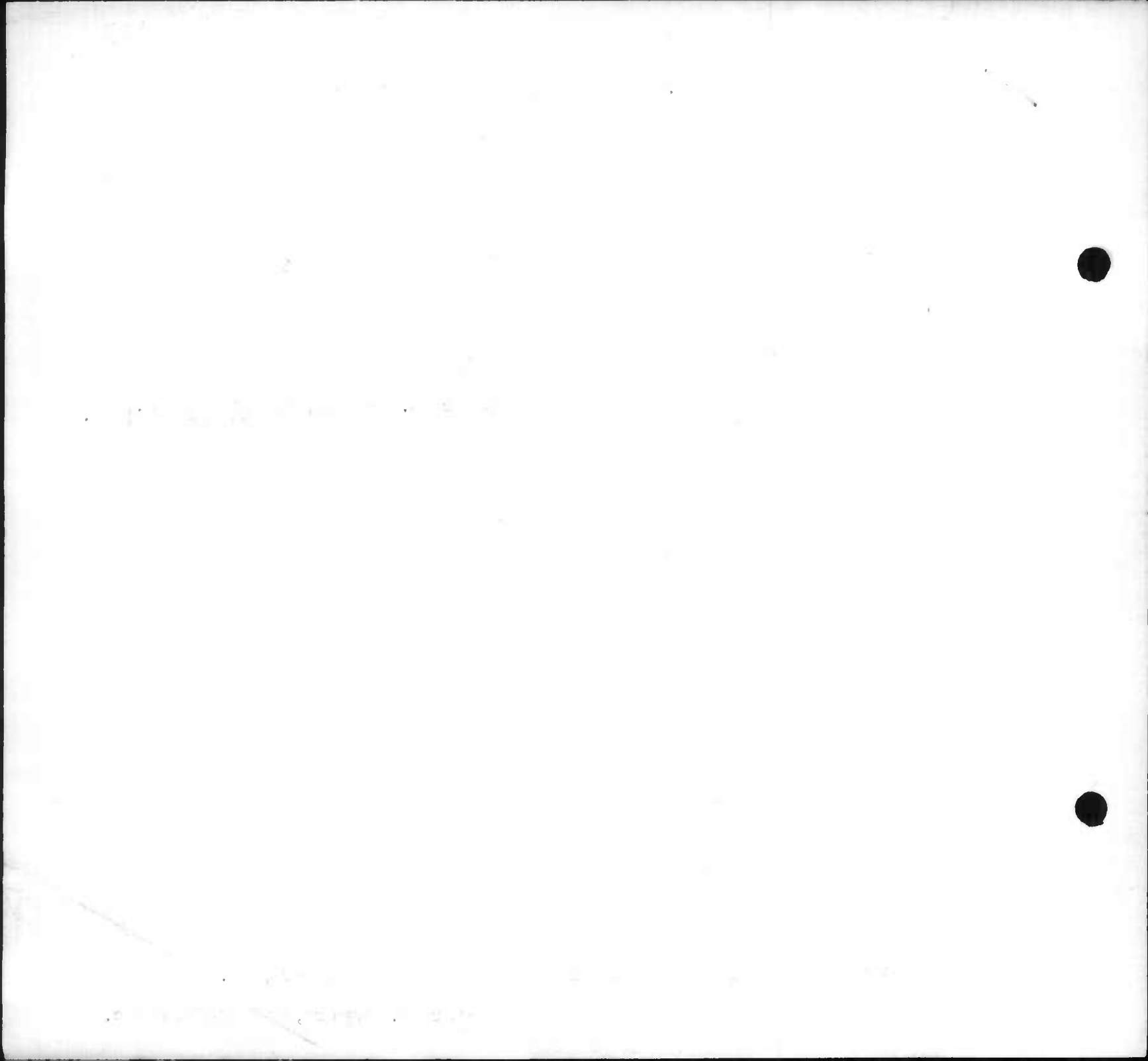
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8616	
B-426 71 8616 BIRTH NO. 1. NAME OF DECEASED <small>(Type or Print)</small> Robert L. Blucher		2. DATE AND HOUR OF DEATH 9-10-71 8.09 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> Bon Secours Hospital 2025 W. Gayette Street Baltimore, Maryland 21223			4. USUAL RESIDENCE <small>(Where deceased lived. If institution; residence before admission)</small> A. STATE Maryland B. COUNTY 2003 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1929 Christian Street		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-12-05	9. AGE <small>(In years last birthday)</small> 65	10. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> Retired
10A. USUAL BUSINESS OR INDUSTRY OT's Elevator			11. BIRTHPLACE <small>(State or foreign country)</small> Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence Blucher			14. MOTHER'S MAIDEN NAME Frances Hermansdorfer		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> Yes World War II			16. SOCIAL SECURITY NO. 212-03-8958		17. INFORMANT Helen S. Reynolds, 1923 Christian St. ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,			CAUSE OF DEATH (A) IMMEDIATE CAUSE Bilateral Bronchopneumonia & CHF DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Carcinomatosis, lung ?		
19A. DATE OF OPERATION 2 non		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED non		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small> non		21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>	
21D. TIME OF INJURY (APPROX.) <small>(Month) (Day) (Year) (Hour)</small>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 9, 1971 to September 10, 1971 that (I) (we) last saw the deceased alive on September 10, 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Somchai Werasophon M.D.				23B. DATE SIGNED 9/10/71	
23C. PHYSICIAN'S NAME (Type) SOMCHAI WERASOPHON M.D.				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> Burial		24B. DATE 9/14/71		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION <small>(City, town, or county)</small> Baltimore, Md.		24E. STATE <small>(State)</small>			
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Hubbard Funeral Home	
ADDRESS 4107 Wilkens Ave.					



FUNERAL DIRECTOR: IMPORTANT

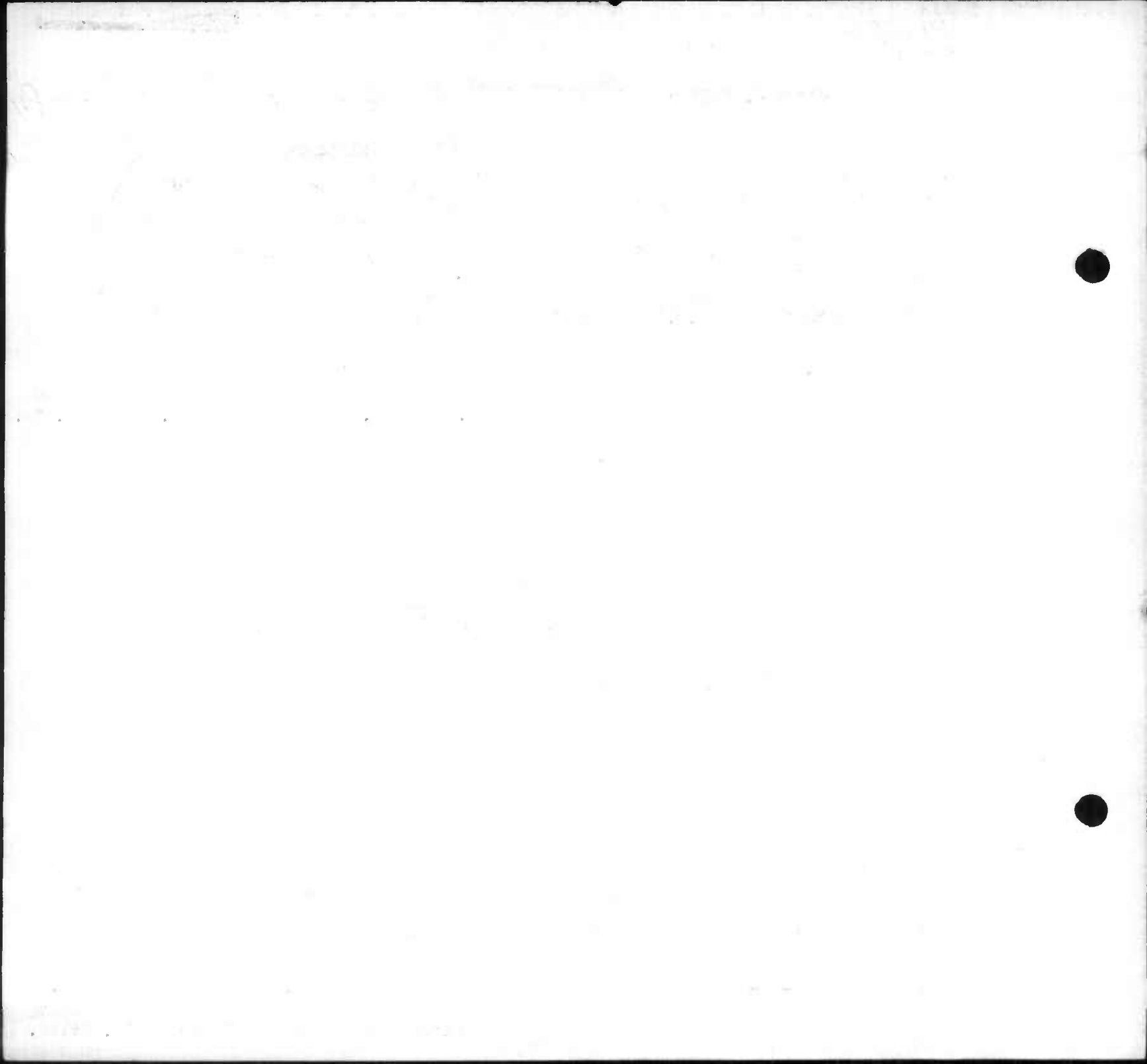
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-340 71 8617		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8617	
1. NAME OF DECEASED (Type or Print) ELIZA beth M. Riddell		2. DATE AND HOUR OF DEATH 9-10-71 / 10⁰⁵ am			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Care Center		4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) A. STATE Maryland B. COUNTY 2864		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/13/27		9. AGE (In years last birthday) 44 yrs.		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Edward Miller		14. MOTHER'S MAIDEN NAME Spillman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Edward L. Riddell, 3216 Hewitt Ave., Silver Springs, Md.	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V. Disease Chronic Brown Syndrome		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Arteriosclerosis (B) A.S.C.V. Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Brown Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/1 19 69 to 9/10 19 71 that (I) (we) last saw the deceased alive on 9/1 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum		23B. DATE SIGNED 9/10/71		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD	
23D. ADDRESS 11154 CALVERT ST					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		24C. NAME OF CEMETERY or CREMATORY Western	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

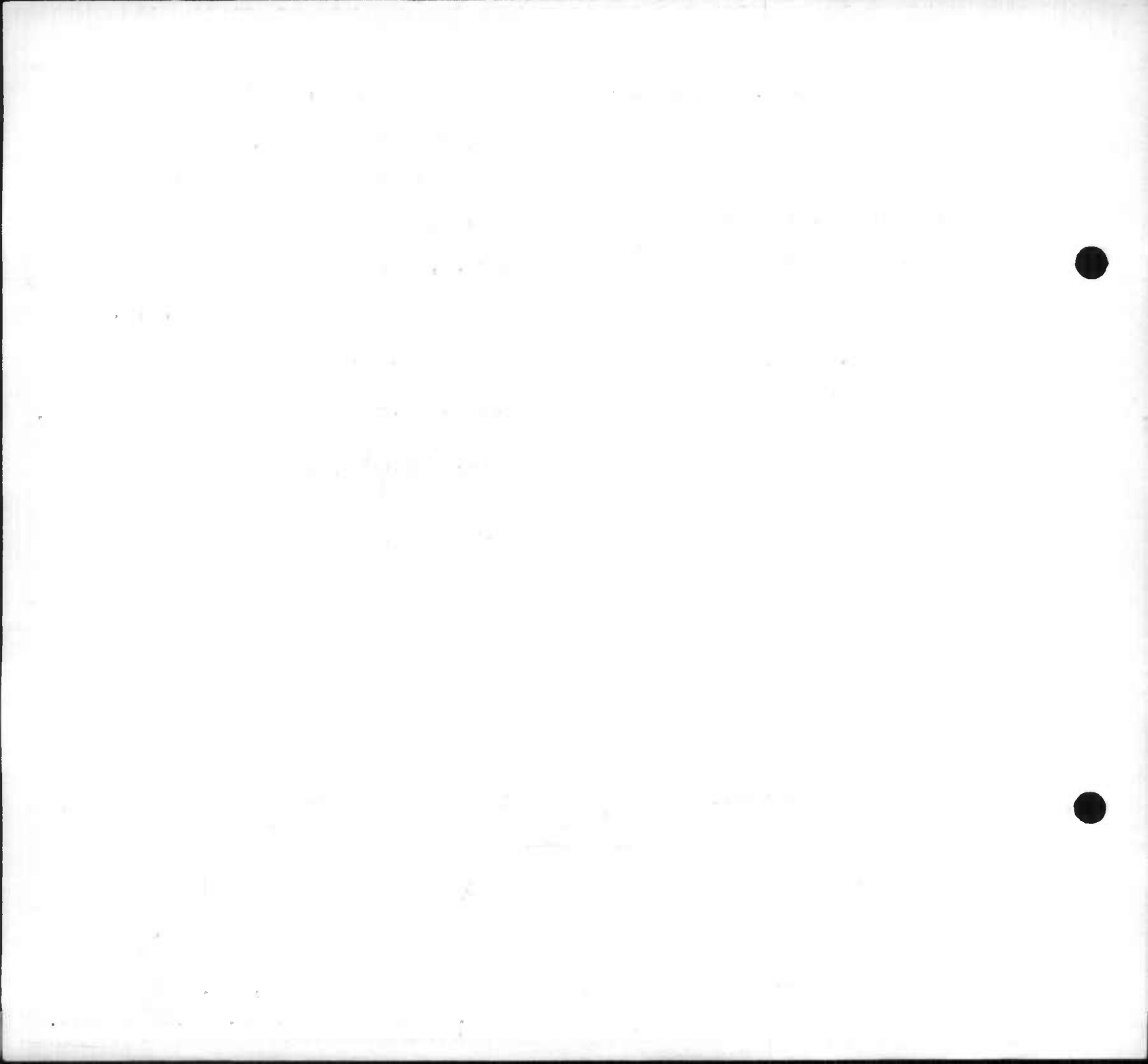
Baltimore City Health Department				REG. NO. 71 8618	
BIRTH NO. 71 8618		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH <u>SEP 11 1971 6:45 PM</u>	
1. NAME OF DECEASED (Type or Print) <u>James J. Miller</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Md. Gen Hosp.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>	
		E. STREET AND NUMBER <u>Rowley's Quarters</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1895</u>	9. AGE (in years last birthday) <u>75</u>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
13. FATHER'S NAME <u>William J. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pendergast</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. <u>226-20-7548</u>		17. INFORMANT <u>Mrs. Ethel R. Miller Box 600 Rt. 14 Balto. Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardioresp. Failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>L.R.O. ABSCESS</u>			
(C) <u>STRANGULATED FEM. HERNIA</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8/30/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Str. Fem. Hernia</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-30-71</u> to <u>9-11-71</u> that (I) (we) last saw the deceased alive on <u>9-11-71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H.S. Ranganathan M.D.</u>		23B. ADDRESS <u>Md. Gen Hosp. Baltimore</u>		23C. DATE SIGNED <u>SEP 11 1971</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-11-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Lassan Funeral Home</u>		25D. ADDRESS <u>7401 Belair Rd. Balto.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

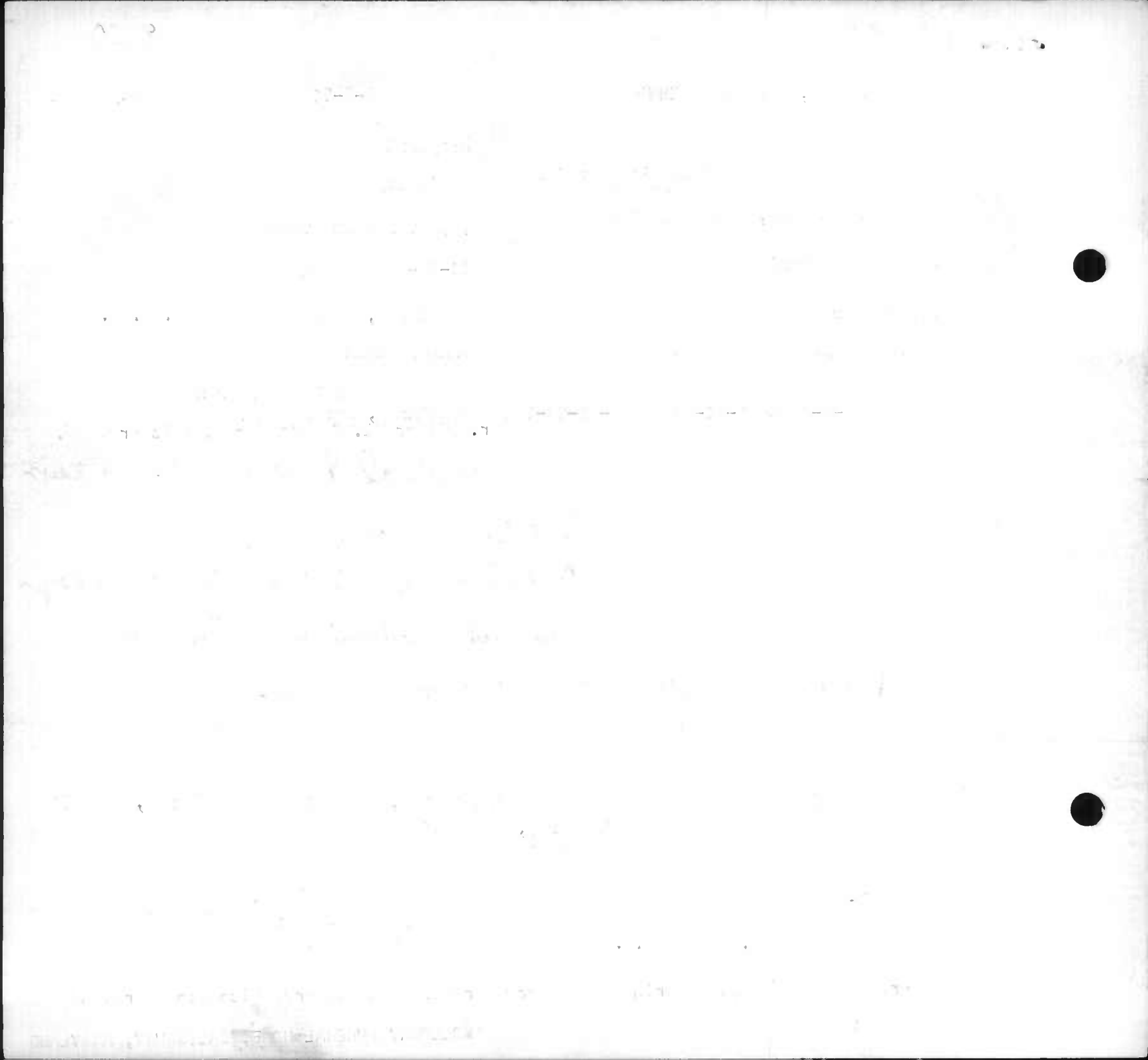
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8619	
BIRTH NO. T-625 71 8619		1. NAME OF DECEASED (Type or Print) Anna M. Trockenbrot		2. DATE AND HOUR OF DEATH Sept 8, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5921 Glenkirk Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto.		
5. SEX Female			6. RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Apr. 1, 1913		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME John W. Neary			14. MOTHER'S MAIDEN NAME Catherine Neary		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 		
17. INFORMANT Timothy Trockenbrot			ADDRESS 5921 Glenkirk Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (B) Arteriosclerosis CVD DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 3 yrs		
19A. DATE OF OPERATION 			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 2 Jan 19 48 to 8 Sept 19 71 that (I) (we) last saw the deceased alive on 11 Aug 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 9 Sept 71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-11-71		
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971			25B. NAME OF REGISTRAR B. Labrowski		
25C. FUNERAL DIRECTOR 2818 E. Baltimore St.			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

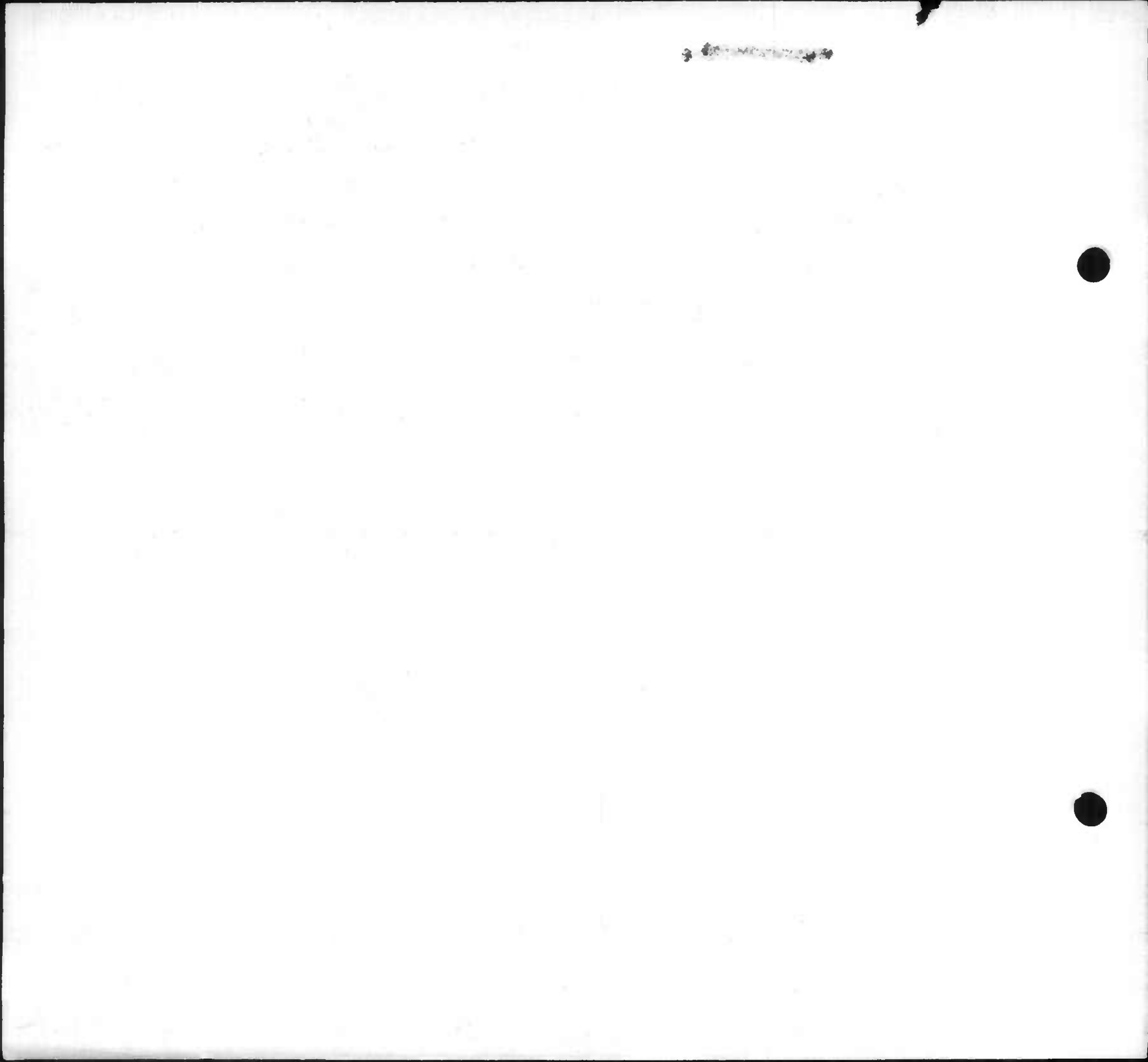
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8620
G-132 71 8620 BIRTH NO.		1. NAME OF DECEASED (Type or Print) GAPETZ, Charles Philip		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		2. DATE AND HOUR OF DEATH 9-9-71 7:30 P.M. 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 7200 C. CITY OR TOWN Salisbury D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 905 Evergreen Avenue		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-98	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10B. KIND OF BUSINESS OR INDUSTRY Bricklayer		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George Gapetz		14. MOTHER'S MAIDEN NAME Martha Baker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8-3-42 to 2-11-43		16. SOCIAL SECURITY NO. 217-03-74-74A		
17. INFORMANT VA Hospital Records Baltimore, Maryland 21218		ADDRESS Baltimore, Maryland 21218		
18. 4339 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Mr. Wilford L. Gapetz (Son), Salisbury, Md. (A) IMMEDIATE CAUSE Bilateral Pulm embolus 4 days DUE TO, OR AS A CONSEQUENCE OF: (B) Prostate carcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) Cerebral edema, post Cerebral aneurysm 4 days aneurysm abdominal aorta 1-27				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Respiratory insufficiency				
19A. DATE OF OPERATION 9/8/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory insufficiency		
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Salisbury, Md.		21B. WHERE DID INJURY OCCUR? In Baltimore City, give exact location		
21C. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21E. HOW DID INJURY OCCUR? While At Work		21F. HOW DID INJURY OCCUR? While At Work		
22. I certify that AS (this hospital) attended the deceased from September 1, 1971 to September 9, 1971 that 1 (we) last saw the deceased alive on September 9, 1971 and that in MD (our) opinion death occurred on the date and hour and from the causes stated above. AS (We) (did) not view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 9/10/71		
23C. PHYSICIAN'S NAME (Type) RICARDO A. CORDON M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/71		
24C. NAME OF CEMETERY or CREMATORY Springhill Memory Gardens		24D. LOCATION (City, town, or county) (State) Salisbury, Wicomico, Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR [Signature]		
25C. FUNERAL DIRECTOR MOLLOY FUNERAL HOME, SALISBURY, MARYLAND		ADDRESS MOLLOY FUNERAL HOME, SALISBURY, MARYLAND		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-263 71 8621		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8621	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Richards, Leroy C.</i>		2. DATE AND HOUR OF DEATH <i>9 PM. Sept 10, 1971</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Hampstead</i>		5. CITY OR TOWN <i>Hampstead</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland 38 Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>Fairmount Rd</i>	
6. SEX <i>Male</i>	7. RACE <i>W.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. DATE OF BIRTH <i>4-13-1921</i>	10. AGE (In years last birthday) <i>50</i>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FOREMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Russel Richards</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hoffacker</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 10-17-42 - 11-30-45</i>		16. SOCIAL SECURITY NO. <i>178-16-0902</i>		17. INFORMANT <i>Bernard Koppi, Lineboro Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Left Ventricular failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Dissecting aneurysm of aorta</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>Sept 10, 1971</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Dissecting aneurysm of aorta</i>		20A. AUTOPSY (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE AND WHEN INJURY OCCURRED (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Ho Jin Bae, MD</i>		23B. DATE SIGNED <i>Sept. 10, 1971</i>		23C. PHYSICIAN'S NAME (Type) <i>Ho Jin Bae, MD</i>	
23D. ADDRESS <i>University of Maryland Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/13/71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>St. David's Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Hanover York Co Pa</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1971</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>Eline Funeral Home</i>		25D. ADDRESS <i>Hampstead Ind.</i>	



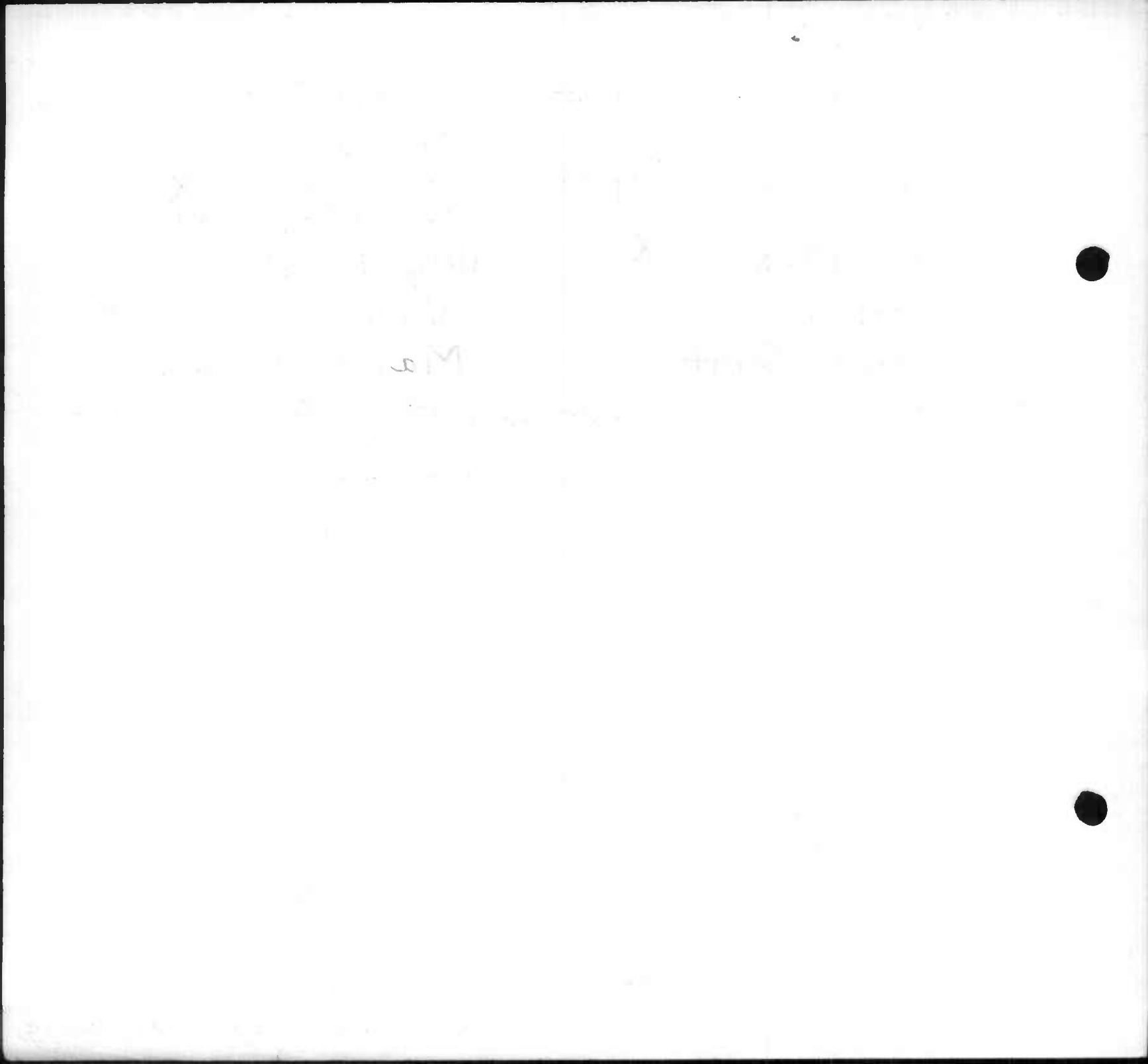
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

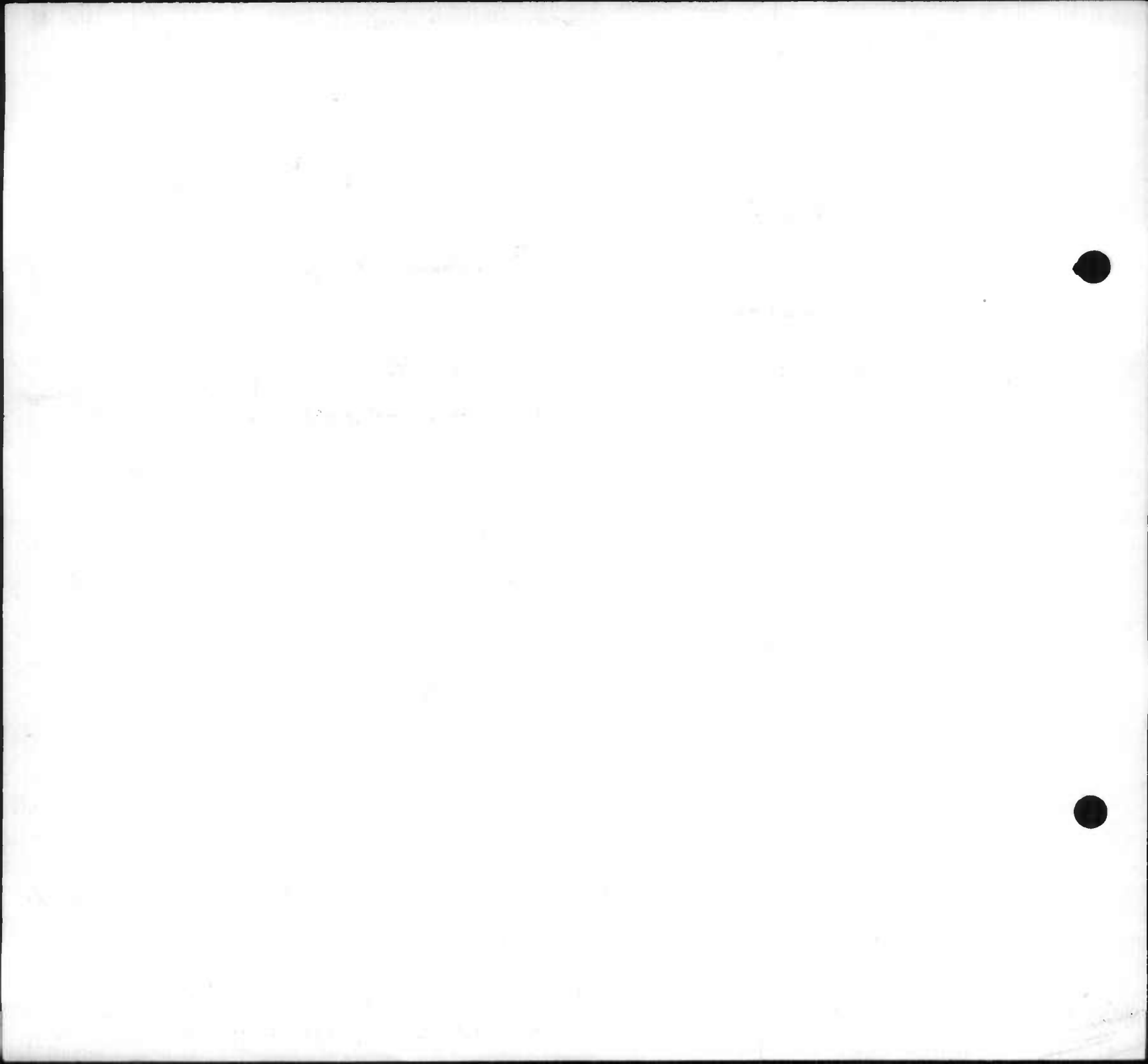
BIRTH NO. S-30071 8622 REG. NO. 71 8622

1. NAME OF DECEASED (Type or Print) <u>Mr. Pleasant # Scott</u>		2. DATE AND HOUR OF DEATH <u>Sept. 8, 1971</u> <u>5⁰⁰ pm.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u> <u>34</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1602</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>503 N. Calhoun St.</u>	
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/09</u>
9. AGE (In years last birthday) <u>61</u>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Amos Scott</u>		14. MOTHER'S MAIDEN NAME <u>Martha Carter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>114-05-7107</u>	
17. INFORMANT <u>Bertha Walton</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Constitutional heart failure</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Antecedent causes</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Rough Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Digitalis Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> 19 <u>71</u> to <u>9-8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Somchai Werasophon</u>		23B. DATE SIGNED <u>9/8/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SOMCHAI WERASOPHON MD</u>		23D. ADDRESS <u>Bon Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/11/71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>mt. Calvary</u>		24D. LOCATION (City, town, or county) <u>AA Co.</u> (State) <u>md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Gaber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Belmont & Schlegel</u>		ADDRESS <u>1727 N. Mount St.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

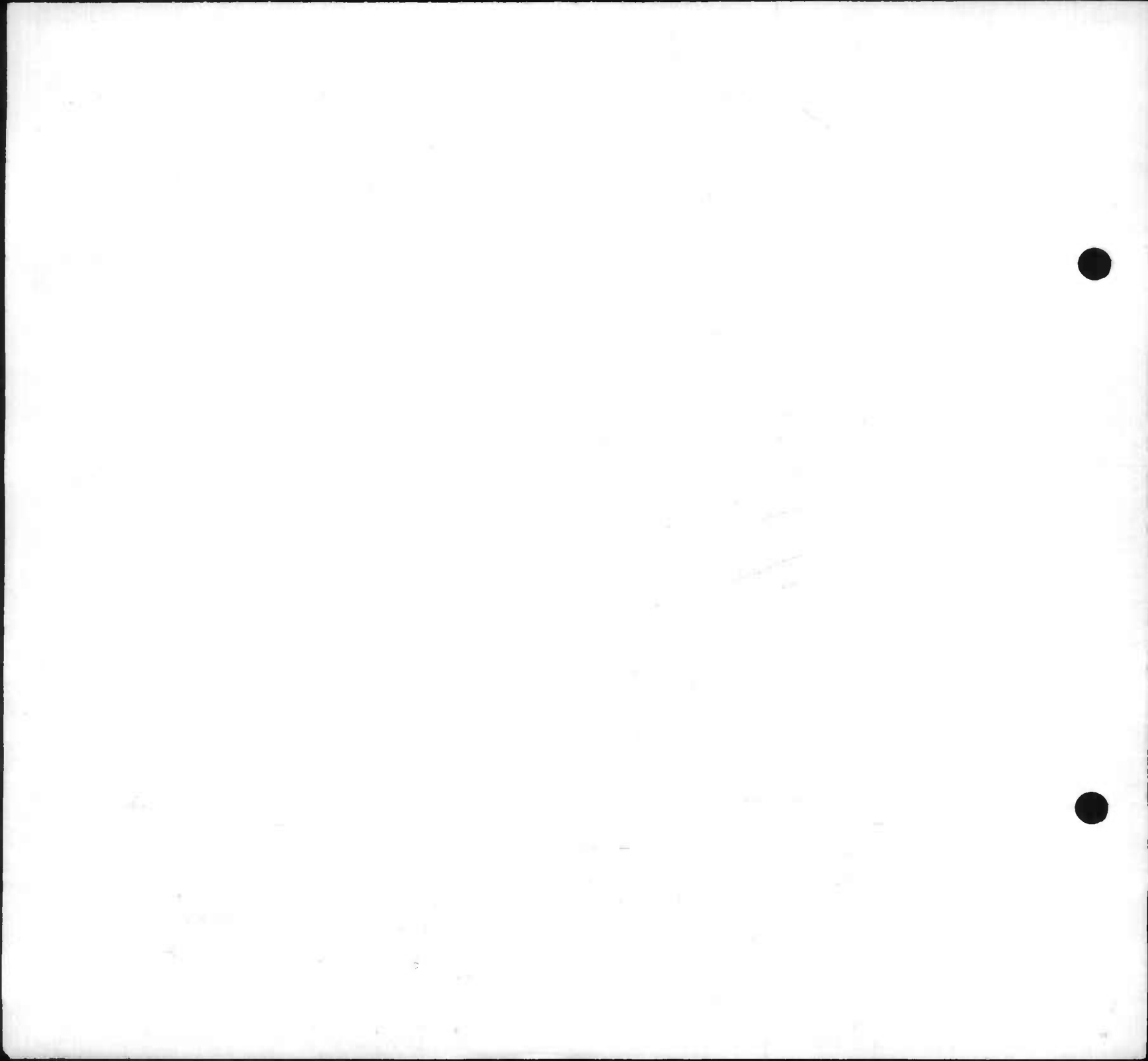
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8623</u>
BIRTH NO. <u>P-456 71 8623</u>		1. NAME OF DECEASED (Type or Print) <u>GERALDINE PALMER</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>7 SEPT 1971</u> <u>1 55 P M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1603</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>BLACK</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>25 March 1904</u>		9. AGE (In years last birthday) <u>67</u>		10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Maid</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Gerimaah Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Smith</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-3261</u>		17. INFORMANT <u>Martha Warrick</u> ADDRESS <u>1611 EDMONSON AVE</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>SHOCK</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PERITONITIS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>INTESTINAL PERFORATION</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DIABETES MELLITUS</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>7 SEPT 19 71</u> to <u>7 SEPT 19 71</u> that (I) (we) last saw the deceased alive on <u>7 SEPT 19 71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>John F. Rogers MD.</u>		23B. DATE SIGNED <u>7 SEPT 71</u>		
23C. PHYSICIAN'S NAME (Type) <u>JOHN F. ROGERS</u>		23D. ADDRESS <u>DEPT. OF MEDICINE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-10-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 14 1971</u>		
25B. NAME OF REGISTRAR <u>Valerie E. Taylor, R.G.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 N. Monroe Street</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

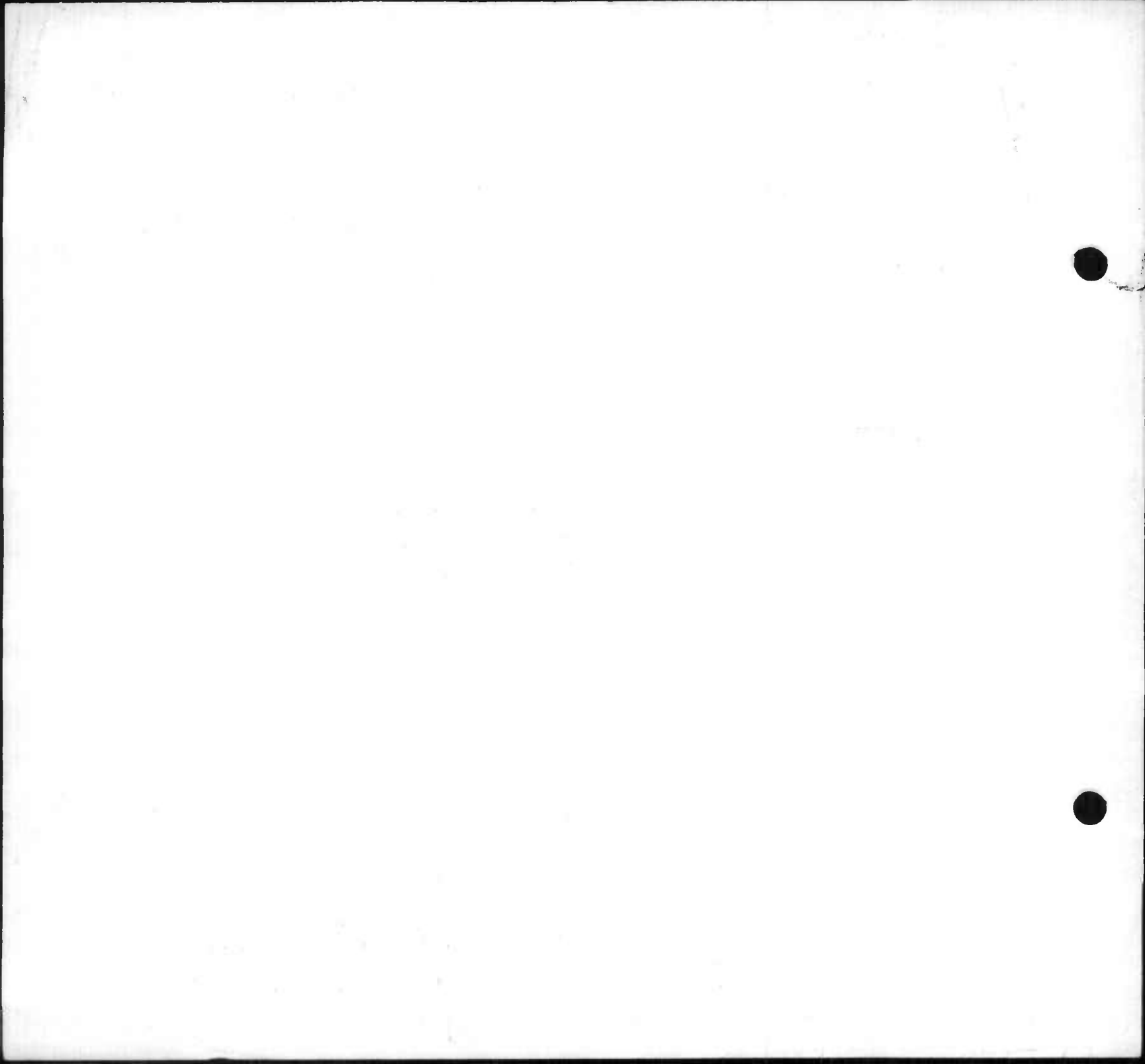
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8624</u>	
BIRTH NO. <u>7-626 71 8624</u>					
1. NAME OF DECEASED (Type or Print) <u>FRAZIER, Nellie</u>		2. DATE AND HOUR OF DEATH <u>8-16-71</u> <u>2:56 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2049 Belvedere Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above course (A) stating the UNDERLYING CONDITION last. <u>Bronchial asthma</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>15 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>February 12, 1970</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>July 29, 1971</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lloyd E. Saylor, M.D.</u>		23B. DATE SIGNED <u>Aug. 27, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor, M. D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-9-71</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-12071 8625		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8625	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James Davis</i>		2. DATE AND HOUR OF DEATH <i>8-31-71 1015 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>561</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1200 Canal Court Apt C1</i>					
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-17-02</i>	9. AGE (in years last birthday) <i>69</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-10-2775</i>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cx of pancreas & metastasis, inoperable</i> (B) <i>Gastric obstruction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Malnutrition 2ndary to #1 Hematemesis 2ndary to #1</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>7-16-1971</i> to <i>8-31-1971</i> that (I) (we) last saw the deceased alive on <i>8-31-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Al. I. Baykaler, M.D.</i>		23B. DATE SIGNED <i>8-31-71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Al. I. BAYKALER M.D.</i>		23D. ADDRESS <i>304 Mc Meekin St. Balt.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>9-9-71</i>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.P.</i>	
25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		25D. ADDRESS			

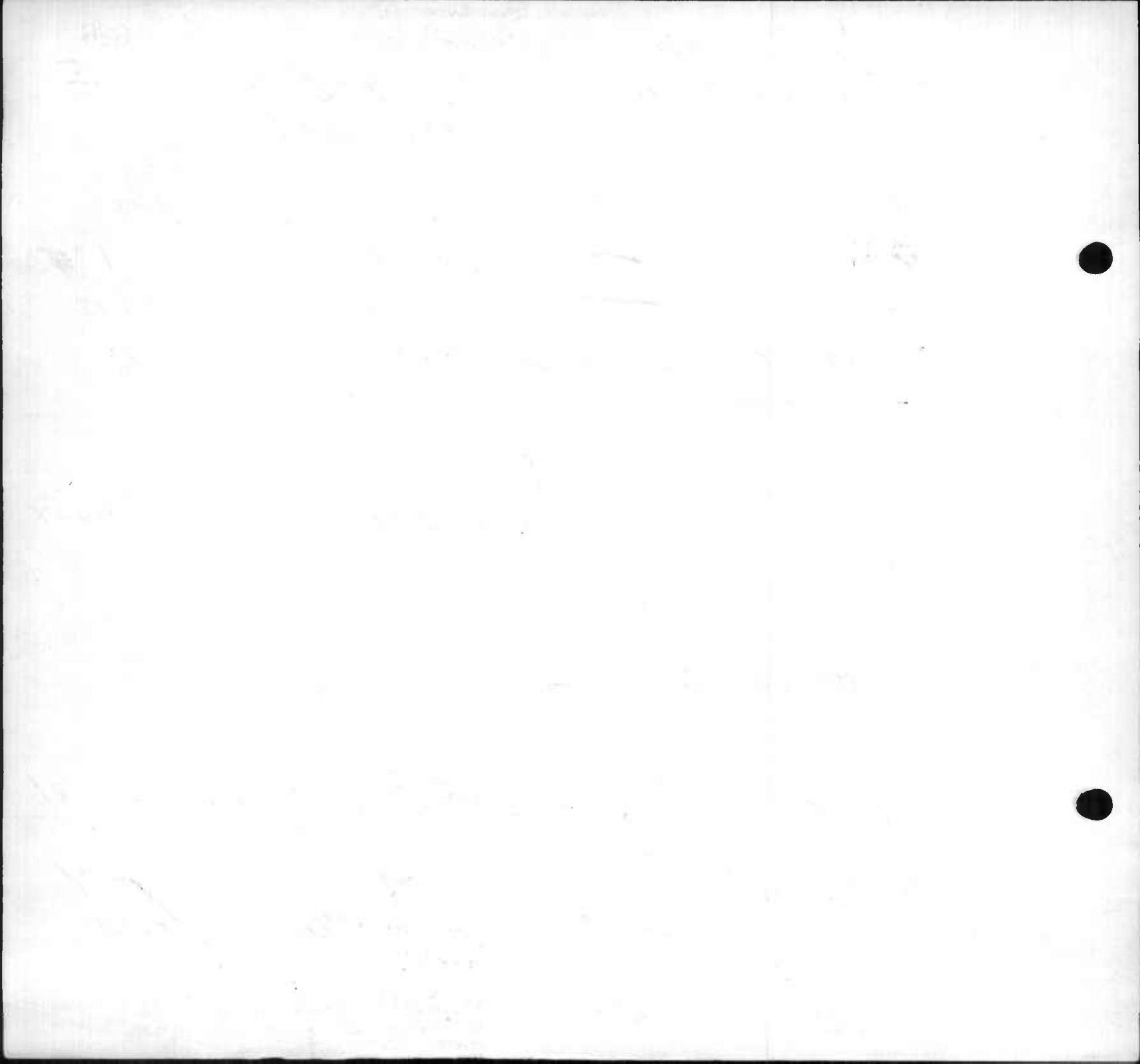


FUNERAL DIRECTOR: IMPORTANT

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B-650 BIRTH NO. 71 8626 M.E. CASE NO. 11-14822				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 71 8626	
1. NAME OF DECEASED (Type or Print) Baby Boy Brown				2. DATE AND HOUR OF DEATH 9-8-71 5:15 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1205 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 305 E. North Ave			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 9-8-71	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harold Richardson			14. MOTHER'S MAIDEN NAME Brown Daisy M				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Prematurity DUE TO Respiratory distress 1 hour DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Antecedent Causes II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Unb artery with		Resp. distress	No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 8 19 71 to Sept 8 19 71 . that (I) (we) last saw the deceased alive on Sept 8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. MURAKOSTH				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-8-71	
23C. PHYSICIAN'S NAME (Type) A. MURAKOSTH				23D. ADDRESS Union Memorial Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-9-71	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. HEALTH DEPARTMENT ADDRESS			

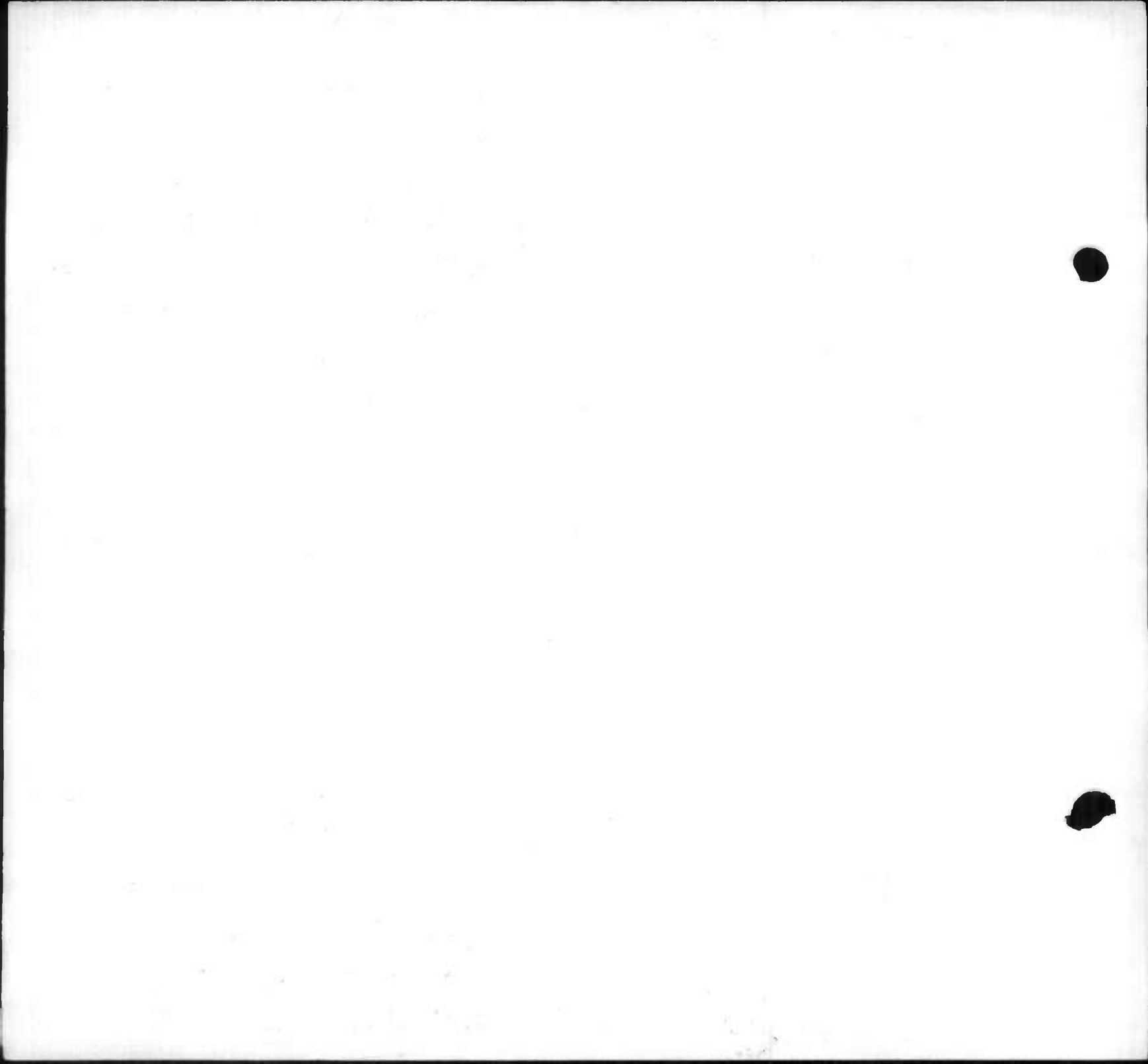
ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHO



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71</u> <u>8627</u> <u>4</u>	
0-520 <u>71</u> <u>8627</u>				BIRTH NO. <u>71-14400</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Owens</u>			2. DATE AND HOUR OF DEATH <u>9-1-71</u> <u>12:40</u> <u>A</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>462</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2210 Fremont Ave</u>		
5. SEX <u>♂</u> <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/71</u>		9. AGE (in years last birthday) <u>2</u> <u>30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Owens, Larry</u>			14. MOTHER'S MAIDEN NAME <u>Peacotte, Sheila</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>—</u> ADDRESS <u>—</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Extreme Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>2 1/2 hrs.</u>	
(C) <u>—</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>71</u> to <u>9/1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>9/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>				23D. ADDRESS <u>—</u>	
DEGREE <u>—</u> ANATOMY BOARD OF MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>		24B. DATE <u>9-9-71</u>		24C. NAME of CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State) <u>—</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. NAME OF PRETOR <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-200 71 8628 BIRTH NO. 71-32047		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8628	
1. NAME OF DECEASED (Type or Print) Baby girl Nicks			2. DATE AND HOUR OF DEATH 9-7-71 18:35 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1203 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 429 Ilchester Ave		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-71	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 1 hr 25 min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, USA.	
13. FATHER'S NAME Earnest Nicks		14. MOTHER'S MAIDEN NAME Boone Carolyn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 763.911 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sepsis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Sepsis (C)		
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Umb. artery cath neonatal resp. distress			20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
22. I certify that (1) (this hospital) attended the deceased from Sept 7 1971 to Sept 7 1971 that (1) (we) last saw the deceased alive on Sept 7 1971 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. MURAKOSHI, M.D.			23B. DATE SIGNED Sept 7 '71		
23C. PHYSICIAN'S NAME (Type) H. MURAKOSHI, M.D.			23D. ADDRESS 1203 Union Memorial Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) 9-9-71			24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		
25A. DATE REC'D BY HEALTH DEPT SEP 14 1971			25B. NAME OF REGISTRAR		

10/20/71 - Cause of Death

Premature rupt. of membranes

Diagnosed as susap. chromosom. xiotics

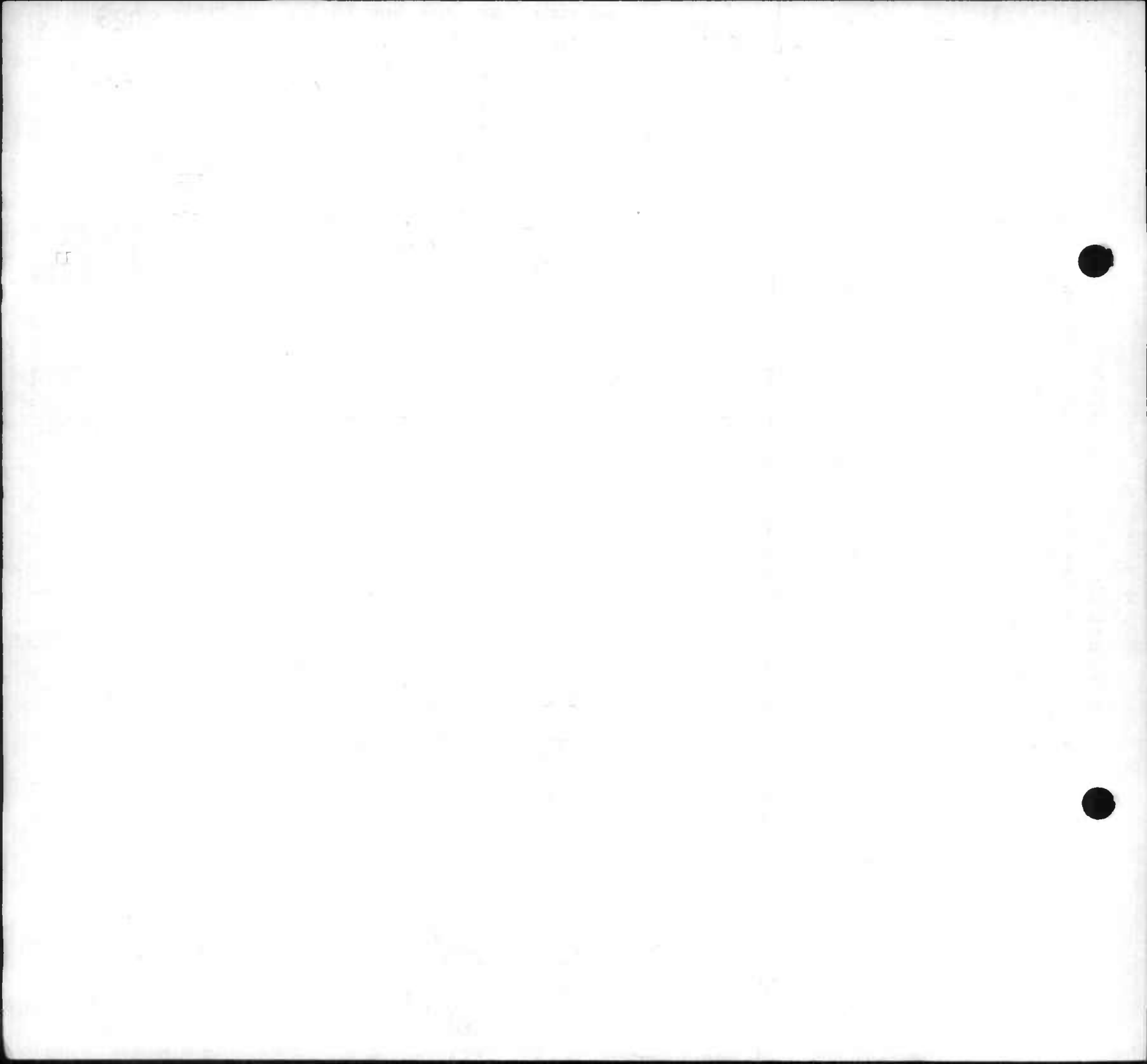
Information from history from Union Mem. Hsp

See Doc't file. Bur of ~~Pro~~ Statistics

FUNERAL DIRECTOR: IMPORTANT

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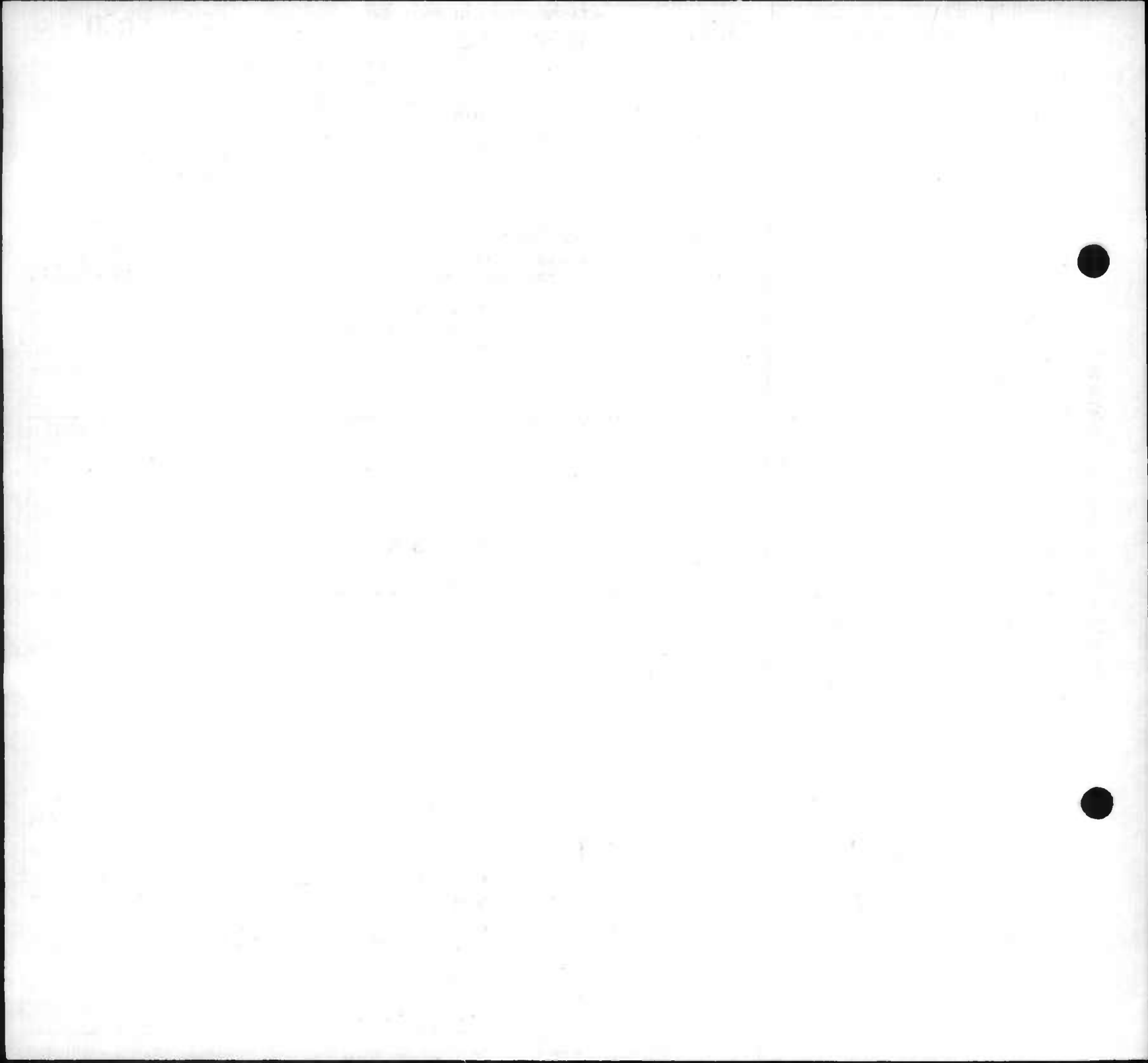
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8629
BIRTH NO. E-152 71-14482 8629		2. DATE AND HOUR OF DEATH 9/2/71 3:47 A M.		
1. NAME OF DECEASED (Type or Print) Baby Girl Evans		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		
5. SEX Female		6. RACE N negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn Infant		10B. KIND OF BUSINESS OR INDUSTRY 		8. DATE OF BIRTH 9/2/71
13. FATHER'S NAME Ronnie Tosian		14. MOTHER'S MAIDEN NAME Loretta Evans		9. AGE (In years last birthday) 11
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland
17. INFORMANT		ADDRESS		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 15%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE IMMATURITY DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (C) </div>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (tt) (this hospital) attended the deceased from 9-2-71 19 to 9-2 19 71 that (tt) (we) last saw the deceased alive on 9-2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Emmanuel N. Macaraeg		23B. DATE SIGNED 9-2-71		23C. PHYSICIAN'S NAME (Type) EMMANUEL N. MACARAEG, M.D.
24A. BURIAL, CREMATION, REMOVAL (Specify) 9-9-71		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BOLD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

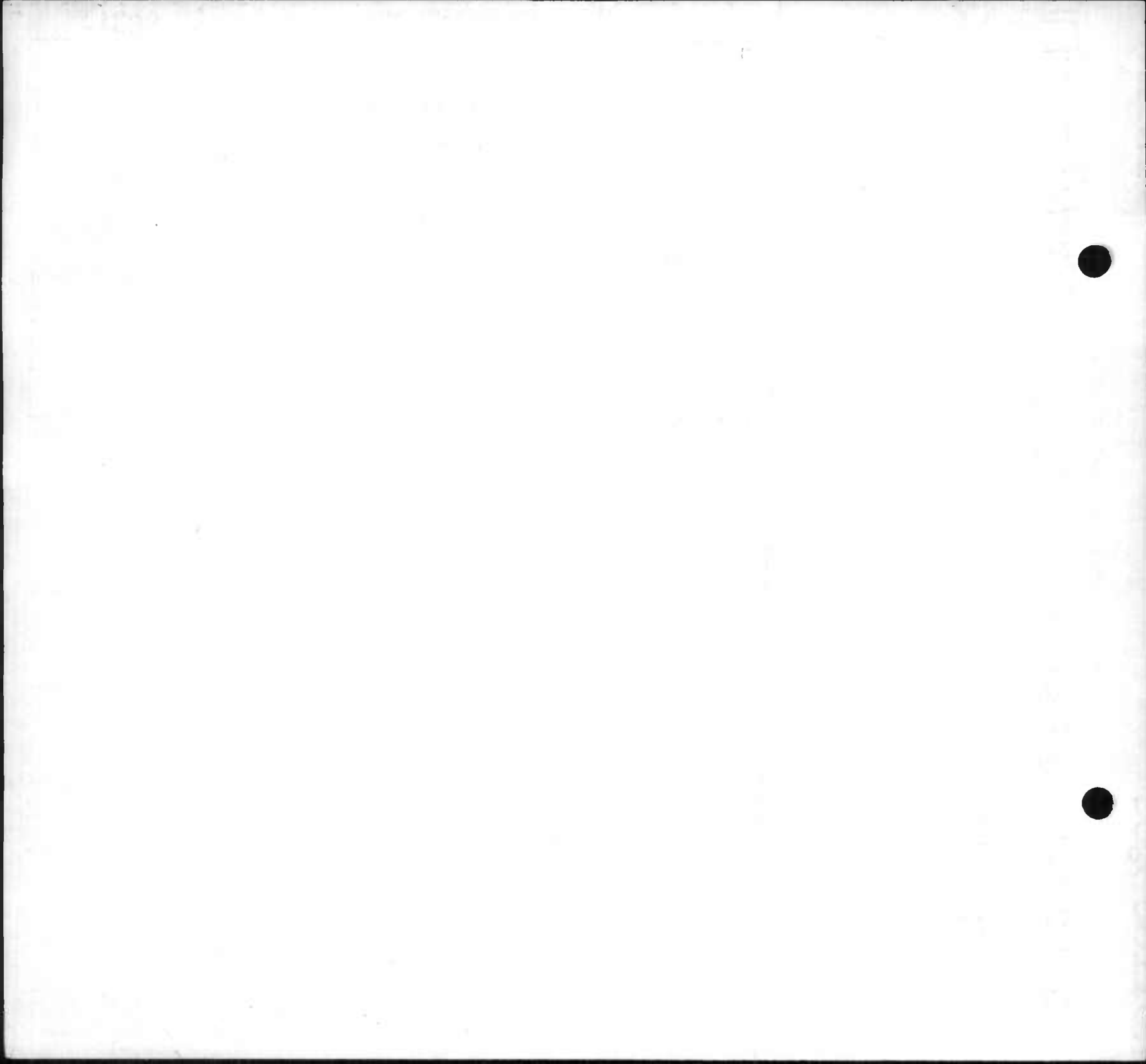
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8630 4
J-525 71 8630 BIRTH NO. 71-14818				
1. NAME OF DECEASED (Type or Print) Baby Day Johnson		2. DATE AND HOUR OF DEATH 9/5/71 3:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		C. CITY OR TOWN County		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER 1000 E. JOHNS RD. APT 102		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/71	9. AGE (In years last birthday) 1 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME RODNEY JOHNSON		14. MOTHER'S MAIDEN NAME SHARON MORAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 777X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) IMMATURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 1/2 M		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If in Baltimore City, give exact location) <input type="checkbox"/> No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR?				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from SEPT 5 19 71 to SEPT 5 19 71 that (I) (we) last saw the deceased alive on SEPT 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Edward H. Cahill MD		23B. DATE SIGNED 9/5/71		
23C. PHYSICIAN'S NAME (Type) EDWARD H. CAHILL MD		23D. ADDRESS 523 STELLA OF BALTIMORE MD		
24A. BURIAL CREMATION, REMOVAL (Specify) 9-9-71		24B. DATE		
24C. NAME of CEMETERY or CREMATOR		24D. LOCATION (City, town or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Fisher, MD		
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD		25D. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8631	
BIRTH NO. 71-13177 8631				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Baby Bay Roberts</i>			2. DATE AND HOUR OF DEATH <i>8/25/71 1:05 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Balto.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>M</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>8/15/71</i>		9. AGE (In years last birthday) <i>10</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>Cathy Roberts</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital chart</i>
18. <i>482.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Neonatal Sepsis with pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>X</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (H) (this hospital) attended the deceased from <i>8/15</i> 19 <i>71</i> to <i>8/25</i> 19 <i>71</i> that (H) (we) last saw the deceased alive on <i>8/25</i> 19 <i>71</i> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James A. Koppee MD</i>				23B. DATE SIGNED <i>8/25/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>James A. Koppee MD</i>				23D. ADDRESS <i>S. B. G. H. ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>9-9-71</i>		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1971</i>		25B. NAME OF REGISTRAR <i>John E. Kelly</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>	

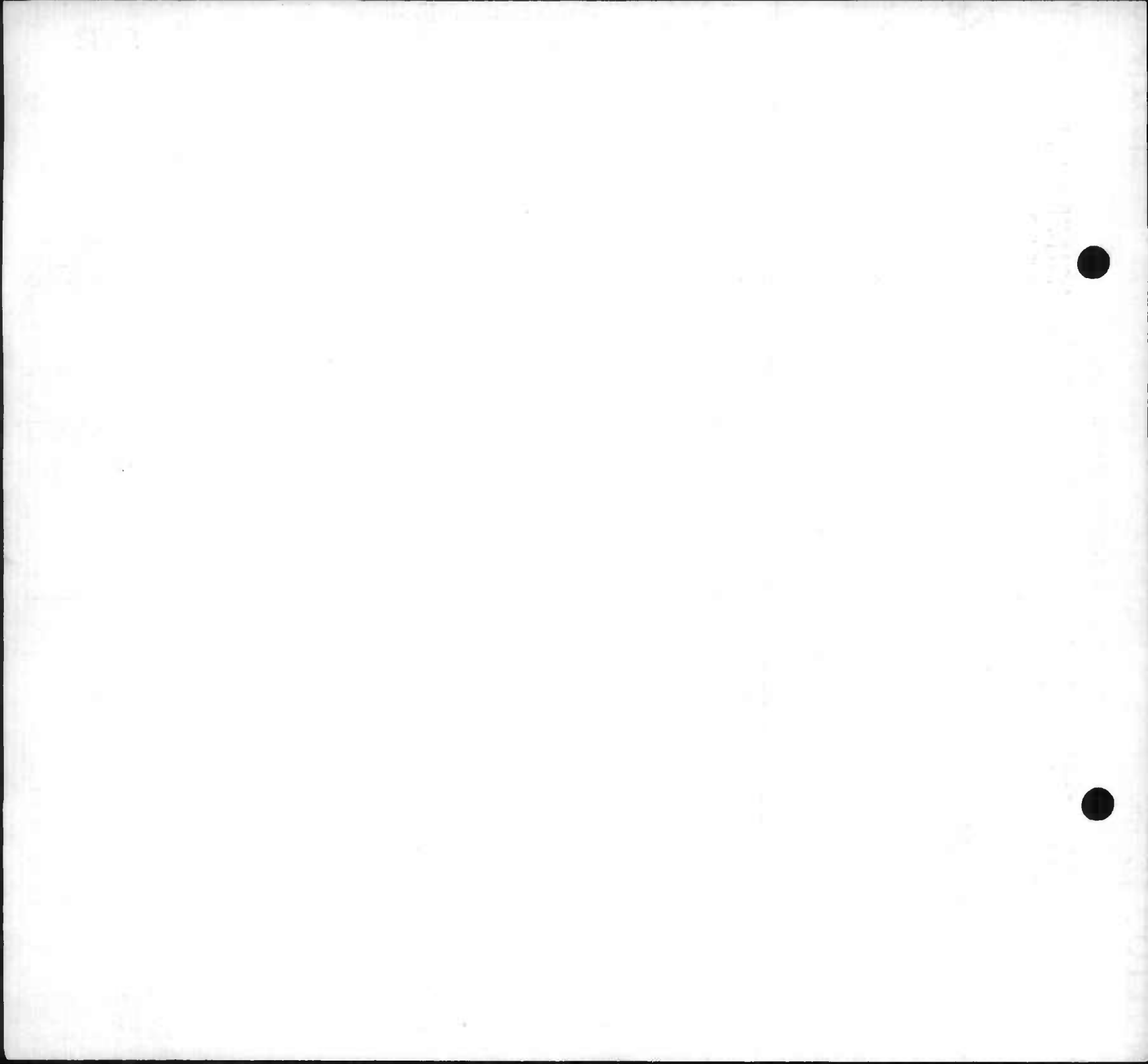


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400 71 8632		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8632
BIRTH NO. 71-13608		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY GIRL BAILEY		2. DATE AND HOUR OF DEATH 8/17/71 8:25 A.M.		
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen'l. Hosp.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 2206 Round Rd., T-2		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/71	9. AGE (In years last birthday) 11 4/5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Dwight		
14. MOTHER'S MAIDEN NAME Elizabeth Wynn		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		
16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 1/2 hrs.
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/16 19 71 to 8/17 19 71 that (I) (we) last saw the deceased alive on 8/17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Mayme Khongcharoensuk, M.D.		23B. DATE SIGNED 8/17/71		23C. PHYSICIAN'S NAME (Type) MAYME KHONGCHAROENSUK, M.D.
23D. ADDRESS SOUTH BAL. GEN. HOSP. BAL. MD.		24A. BURIAL CREMATION, REMOVAL (Specify) 9-9-71		
24B. DATE SEP 14 1971		24C. NAME OF CEMETERY or CREMATOR Robert E. Taylor, & Co.		
24D. NAME OF REGISTRAR		25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		
25B. NAME OF REGISTRAR		25C. NAME OF REGISTRAR		

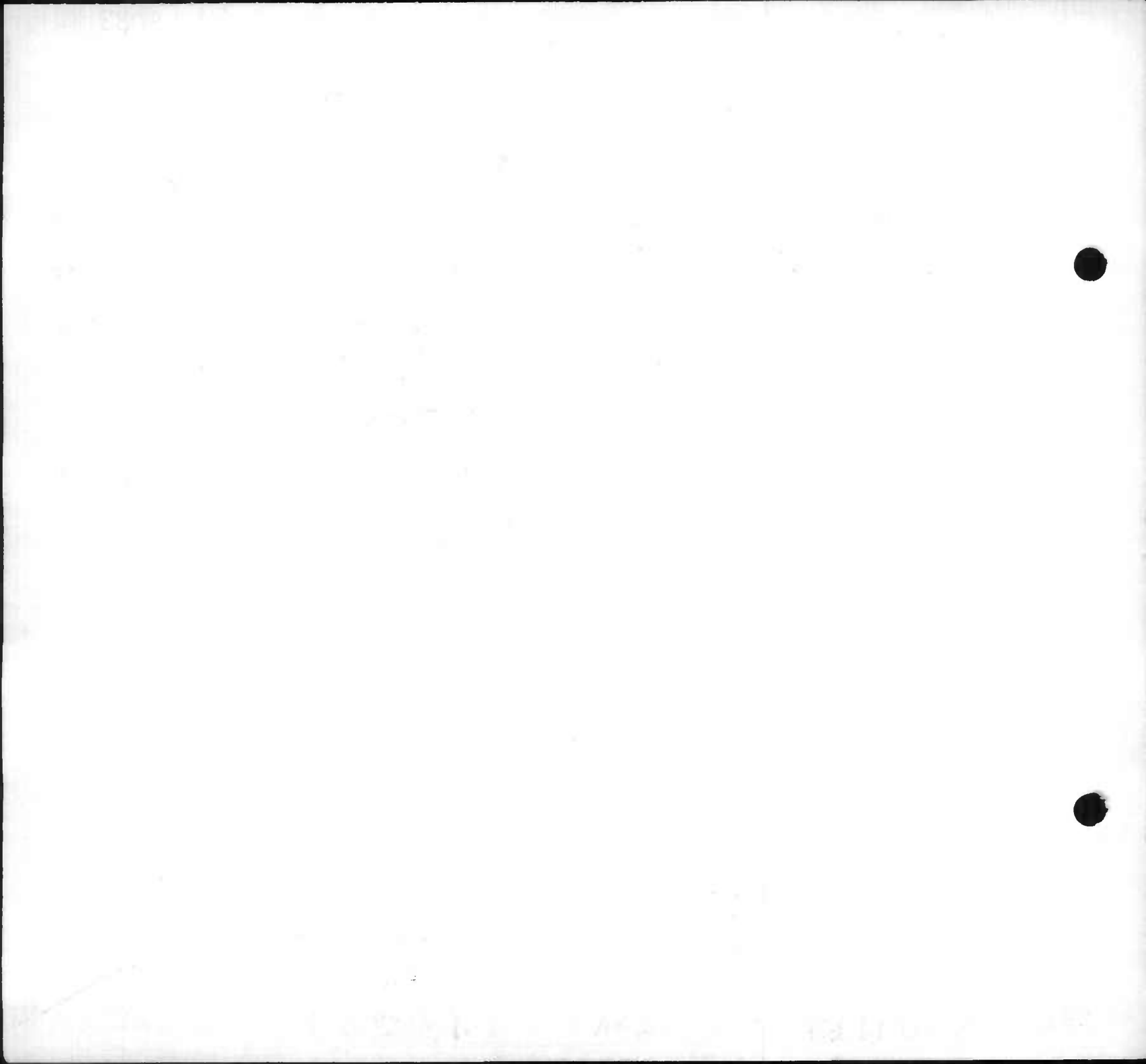
ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

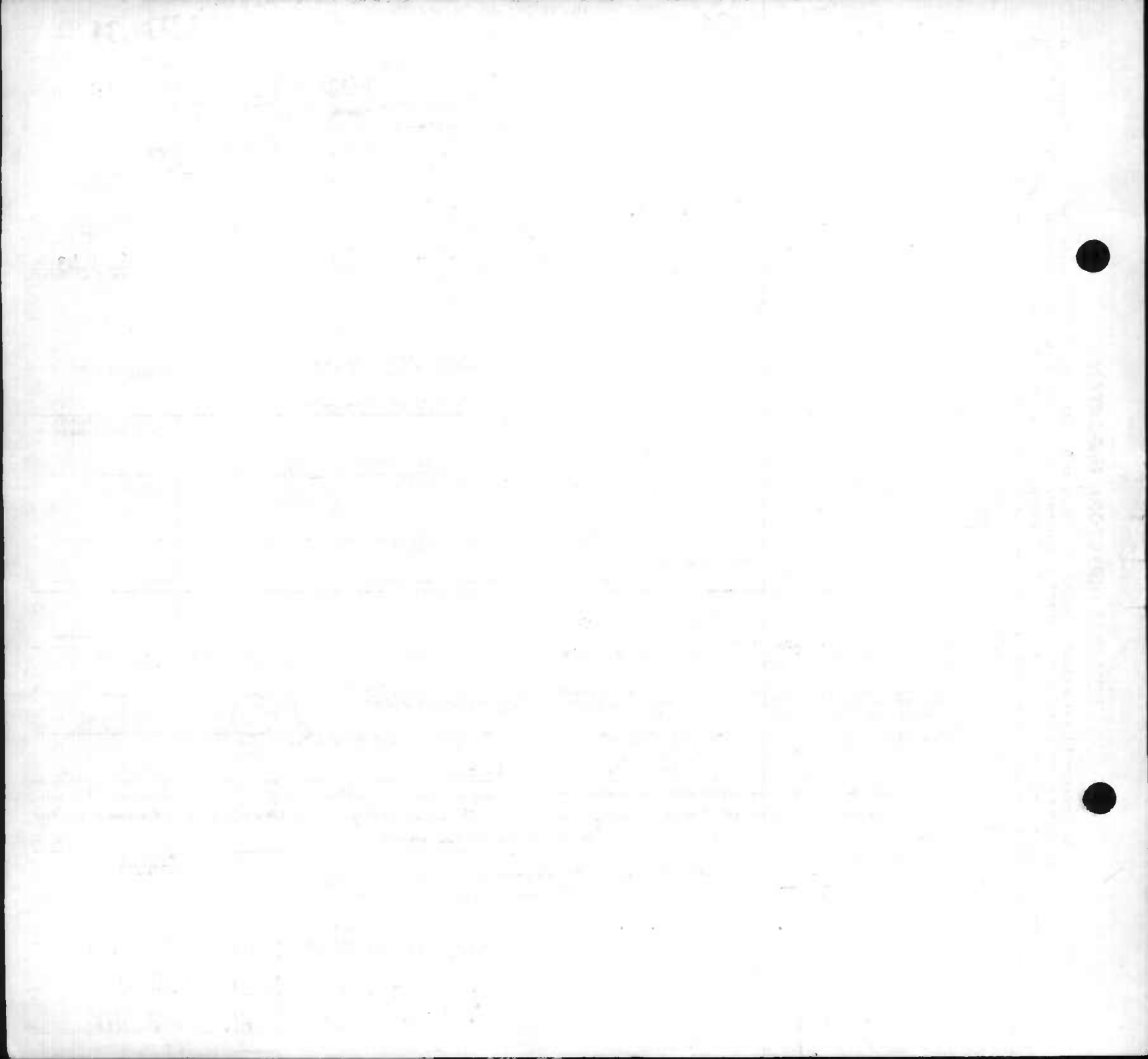
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8633	
J-520 71 8633 BIRTH NO. 21-13581					
1. NAME OF DECEASED (Type or Print) Baby Boy Jones		2. DATE AND HOUR OF DEATH 8/18/71 8 42 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1608			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 640 Wildwood Parkway					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/71	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States					
13. FATHER'S NAME Zola Reid Jones		14. MOTHER'S MAIDEN NAME Mary Velma GRAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mother	
ADDRESS Same					
18. 77001 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (a) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Neonatal asphyxia DUE TO, OR AS A CONSEQUENCE OF: Abruptio Placenta (B) Abruptio Placenta DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mins	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		maternal hemorrhage from abruptio placenta			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8/18 19 71 to 8/18 19 71 that (H) (we) last saw the deceased alive on 8/18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Kopper		23B. DATE SIGNED 8/18/71			
23C. PHYSICIAN'S NAME (Type) James Kopper		23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION REMOVAL (Specify) 9-9-71		24B. DATE		24C. NAME of CEMETERY or CREMATORY MORTUARY SERVICE - BMD	
24D. LOCATION (City, town or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. SEP 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 4	



FUNERAL DIRECTOR: IMPORTANT

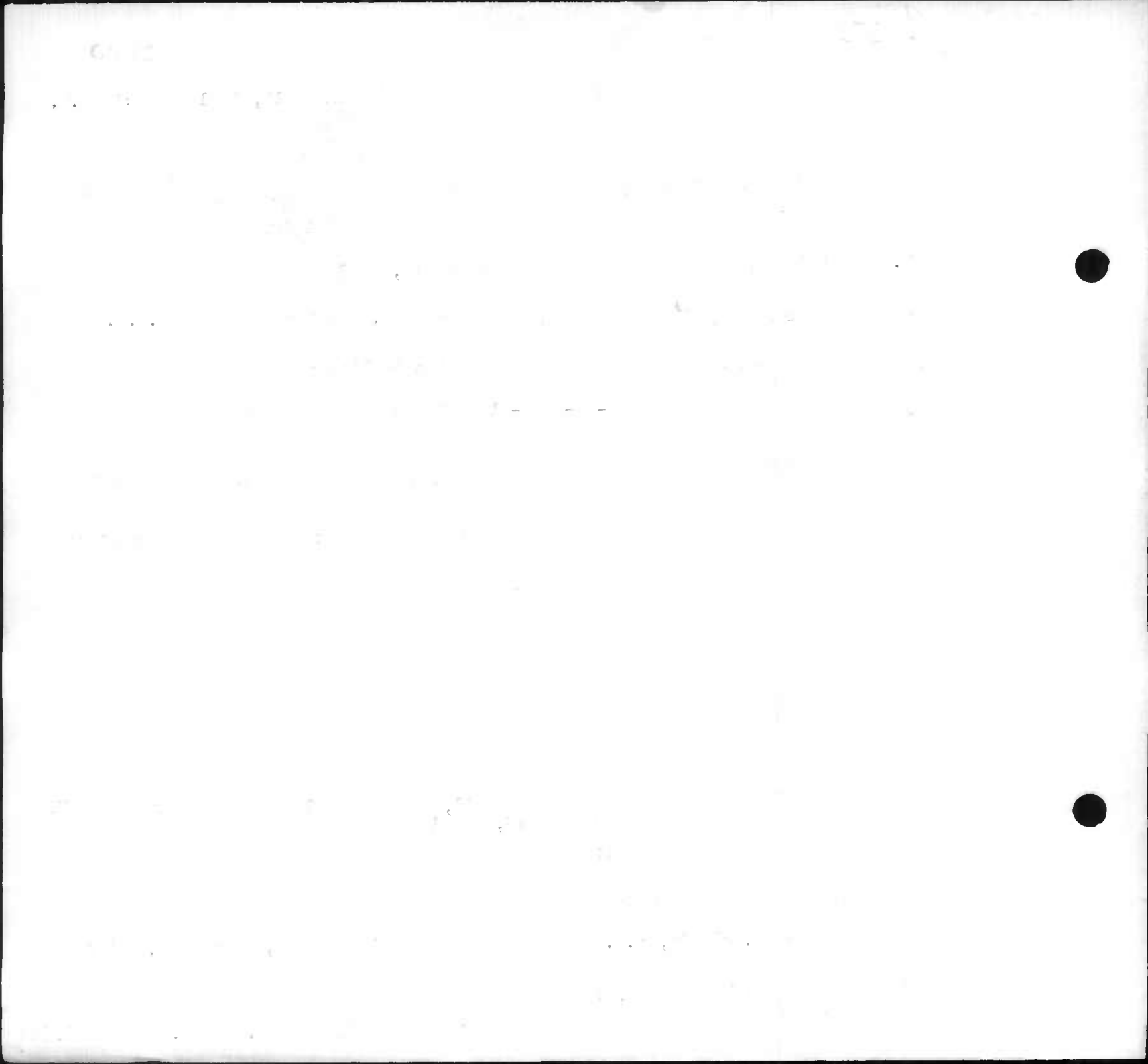
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8634 4</u>
<p><u>J-520 71 8634</u> BIRTH NO. <u>71-14401</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Baby Girl Jones</u></p>		<p>2. DATE AND HOUR OF DEATH <u>8/30/71</u> <u>7:15 P.M.</u></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital, Inc.</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1510</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>4010 Penhurst Ave</u></p>		
<p>5. SEX <u>Female</u></p>	<p>6. RACE <u>Negro</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>8-30-71</u></p>	<p>9. AGE (In years last birthday) <u>6</u> <u>13</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn Infant</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		
<p>13. FATHER'S NAME <u>Unknown</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Geraldine Jones</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <u>Hospital Records</u></p>		
<p>18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Severe Prematurity</u></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:</p>		
<p>19A. DATE OF OPERATION <u>9-2-71</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Eugenia B. Utzurum M.D.</u> DEGREE <u>M.D.</u></p>				<p>23B. DATE SIGNED <u>8-30-71</u></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>Eugenia B. Utzurum M.D.</u></p>				<p>23D. ADDRESS <u>Mercy Hospital</u></p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-2-71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 14 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u></p>		
<p>25C. NAME OF REGISTRAR <u>UNIVERSITY MEDICAL SCHOOL</u></p>				
<p>25D. NAME OF REGISTRAR <u>MORTUARY SERVICE - BCHD</u></p>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

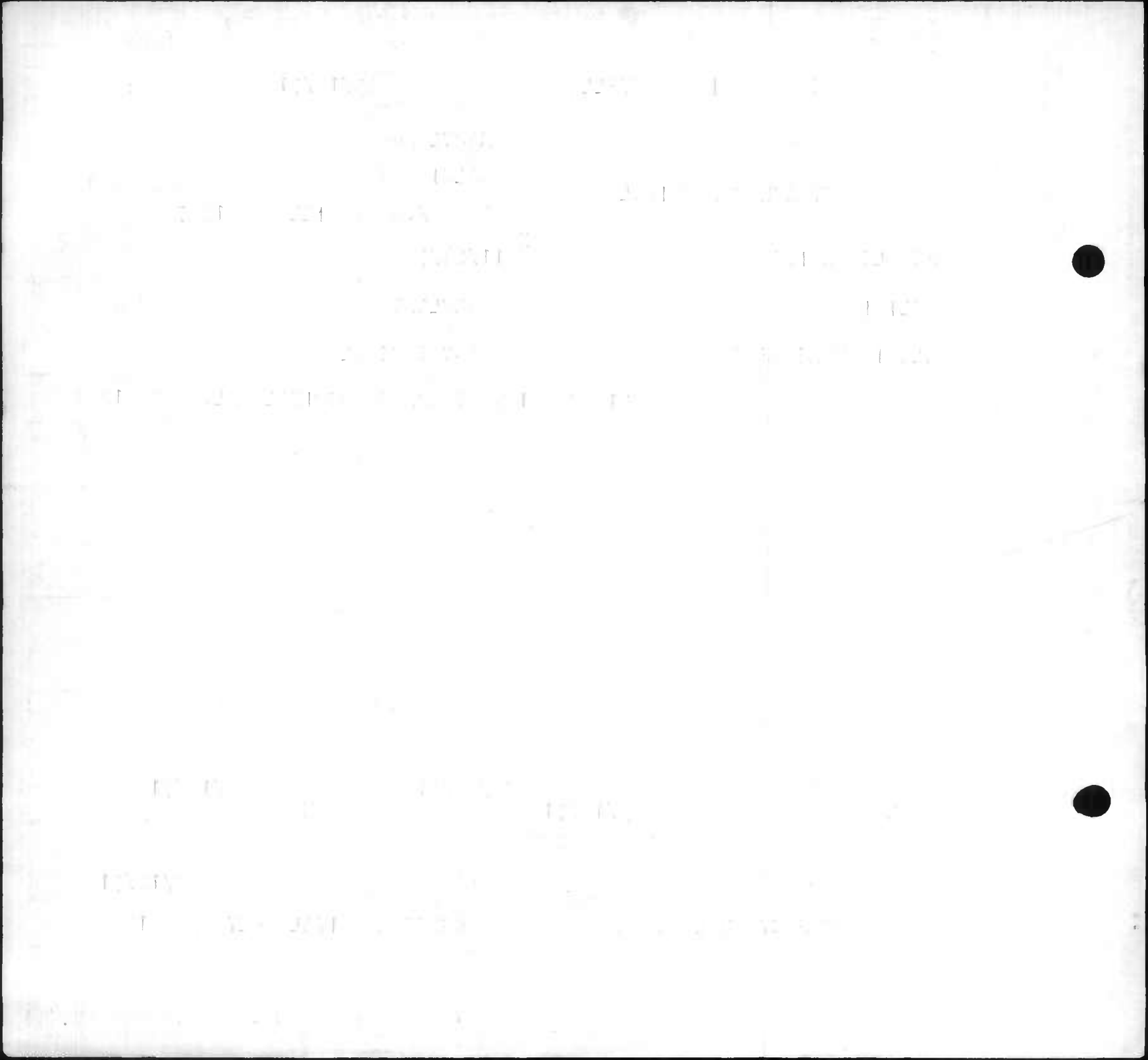
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8635</u>	
P-236 71 8635 CERTIFICATE OF DEATH					
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>Sister Catherine Pfister</u>		2. DATE AND HOUR OF DEATH <u>September 12, 1971</u> <u>7:10 P.M.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>94 Villa Saint Michael</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4000 Forest Hill Road</u>		
5. SEX <u>F.</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1893</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper -retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Sister of Charity</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Joseph Pfister</u>		
14. MOTHER'S MAIDEN NAME <u>Louise Amelia Schanze</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>219-54-0657-J1</u>			17. INFORMANT <u>Sister Andrea</u> ADDRESS <u>same address</u>		
18. <u>43119 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>19 years</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/14/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>52</u> to <u>September</u> , 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>September 10</u> , 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <u>Damian P. Alagia</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Damian P. Alagia, M.D.</u>				23D. ADDRESS <u>3326 Frederick Avenue, Baltimore, 21228</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/14/71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Joseph's Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>			
25B. NAME of REGISTRAR <u>John E. Hall, Jr.</u>		25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO. 108 W. NORTH AV. (1)</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

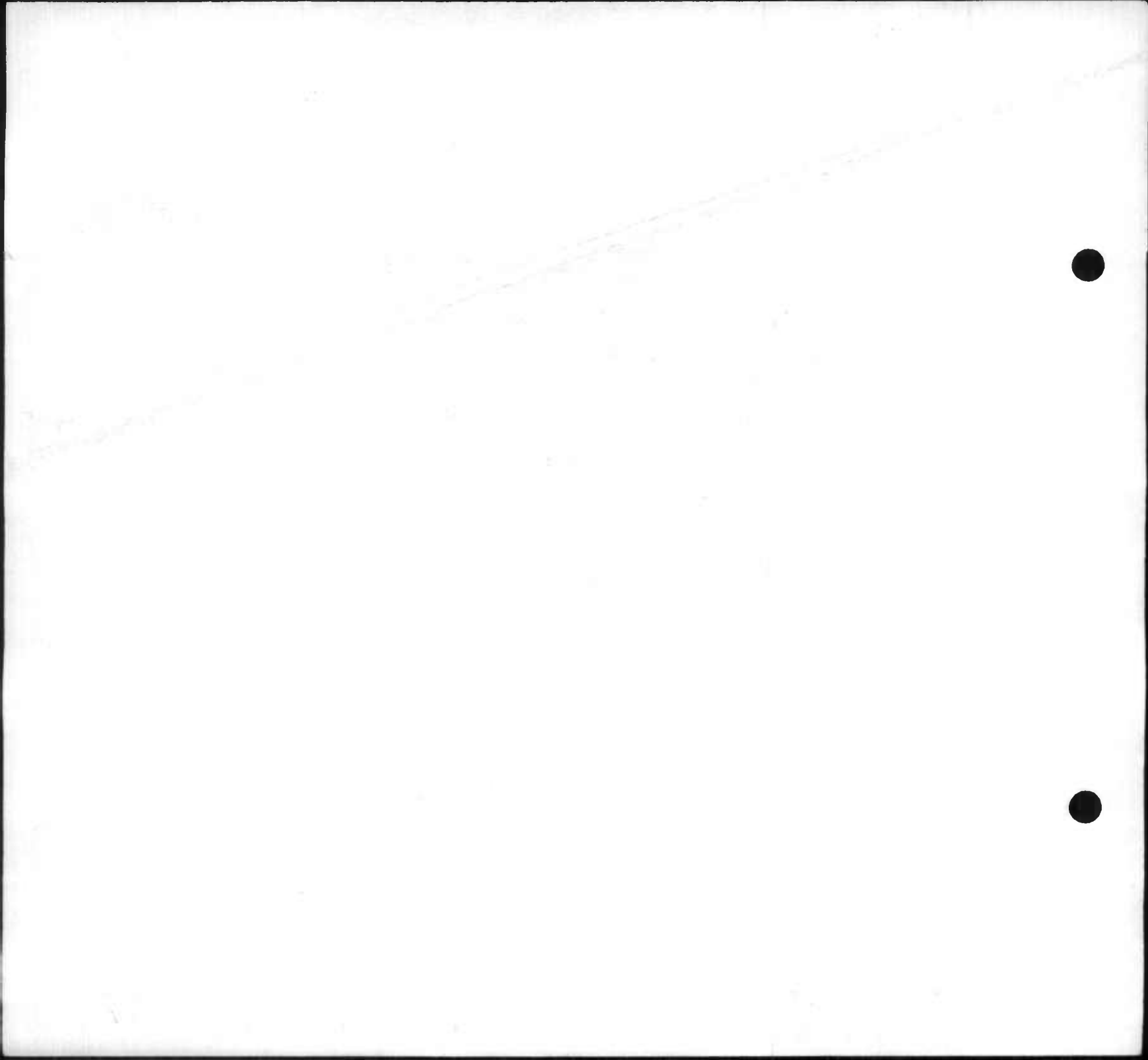
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8636	
BIRTH NO. K-162 71 8636				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KEEPERS SISTER STELLA			2. DATE AND HOUR OF DEATH 09/12/71 2:45 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2841 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 FOREST HILL RD 21207		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/78		9. AGE (In years lost birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALEXIX V KEEPERS			14. MOTHER'S MAIDEN NAME MARY E SEBOLD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219 54 0182		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute renal failure 2 days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute cholecystitis			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus			(C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (IX) (this hospital) attended the deceased from 09/02/71 to 09/12/71 and that (IX) (we) last saw the deceased alive on 09/12/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Perfecto Valarao</i>				23B. DATE SIGNED 09/12/71	
23C. PHYSICIAN'S NAME (Type) PERFECTO VALARAO MD				23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71		24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION Emmitsburg, Maryland		25A. DATE REC'D. BY HEALTH DEPT. SEP 15 1971			
25B. NAME OF REGISTRAR <i>Robert C. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. NORTH AV. (1)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

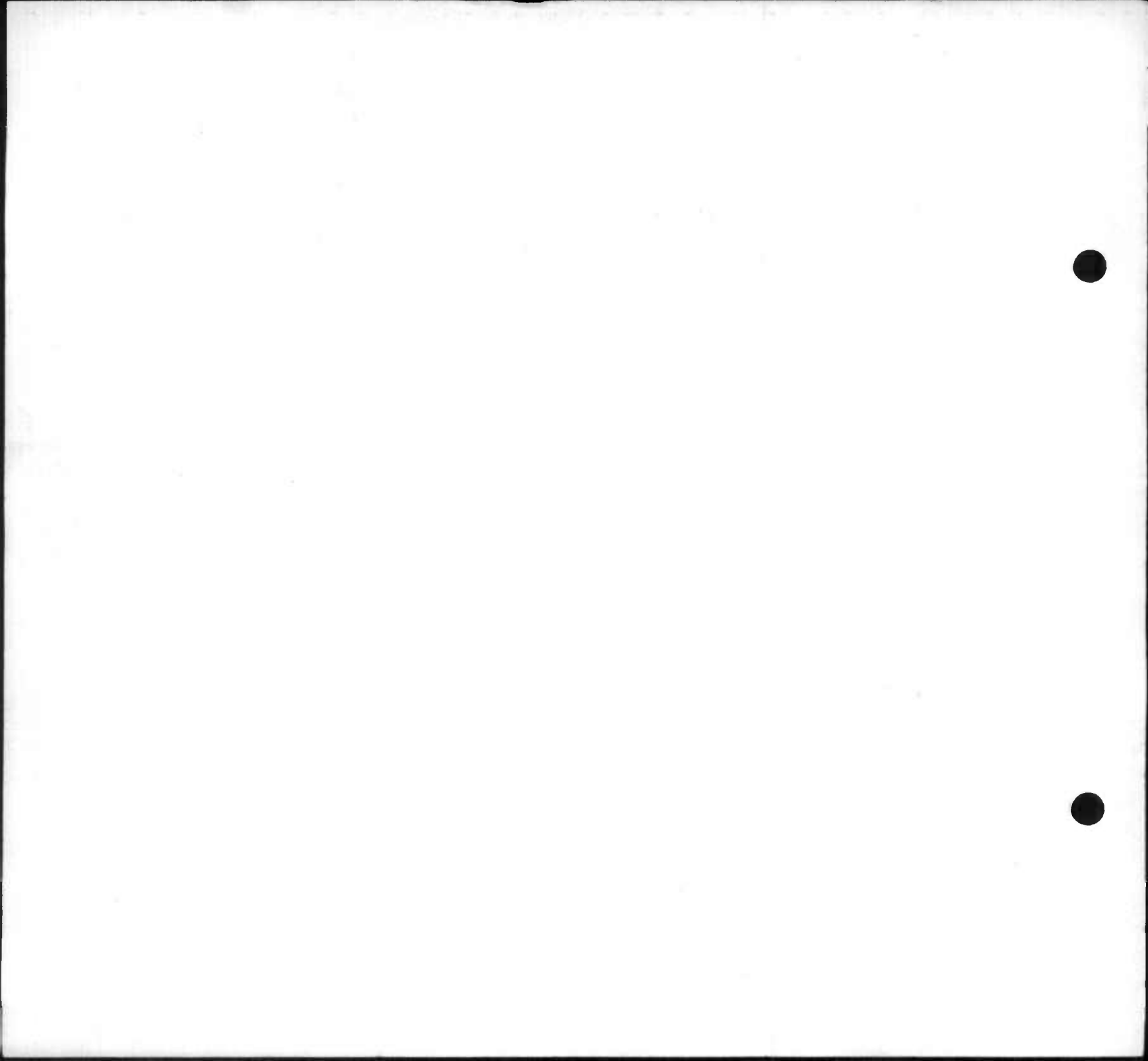
B-230				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8637	
BIRTH NO. 71 8637 Buckheit				2. DATE AND HOUR OF DEATH 9/14/71 12:10 A.M.					
1. NAME OF DECEASED (Type or Print) GEORGE BUCKHEIT				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2102		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE Cauc				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/01/93		9. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nat. Engineer				10B. KIND OF BUSINESS OR INDUSTRY Building Ind.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Buckheit				14. MOTHER'S MAIDEN NAME Carrie Bolander					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mary E. Buckheit 910 S. Carey St.			
18. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) A.S.C.U.D.		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Armed D.O.A. 9/4/71 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE George H. Brocillet J. MD		23B. DATE SIGNED 9/19/71		23C. PHYSICIAN'S NAME (Type) GEORGE H. BROUILLET J. MD	
24A. BURIAL CREMATION REMOVAL (Specify) Burial				24B. DATE 9/17/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glenburne Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR John J. Carrington Inc. 25 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

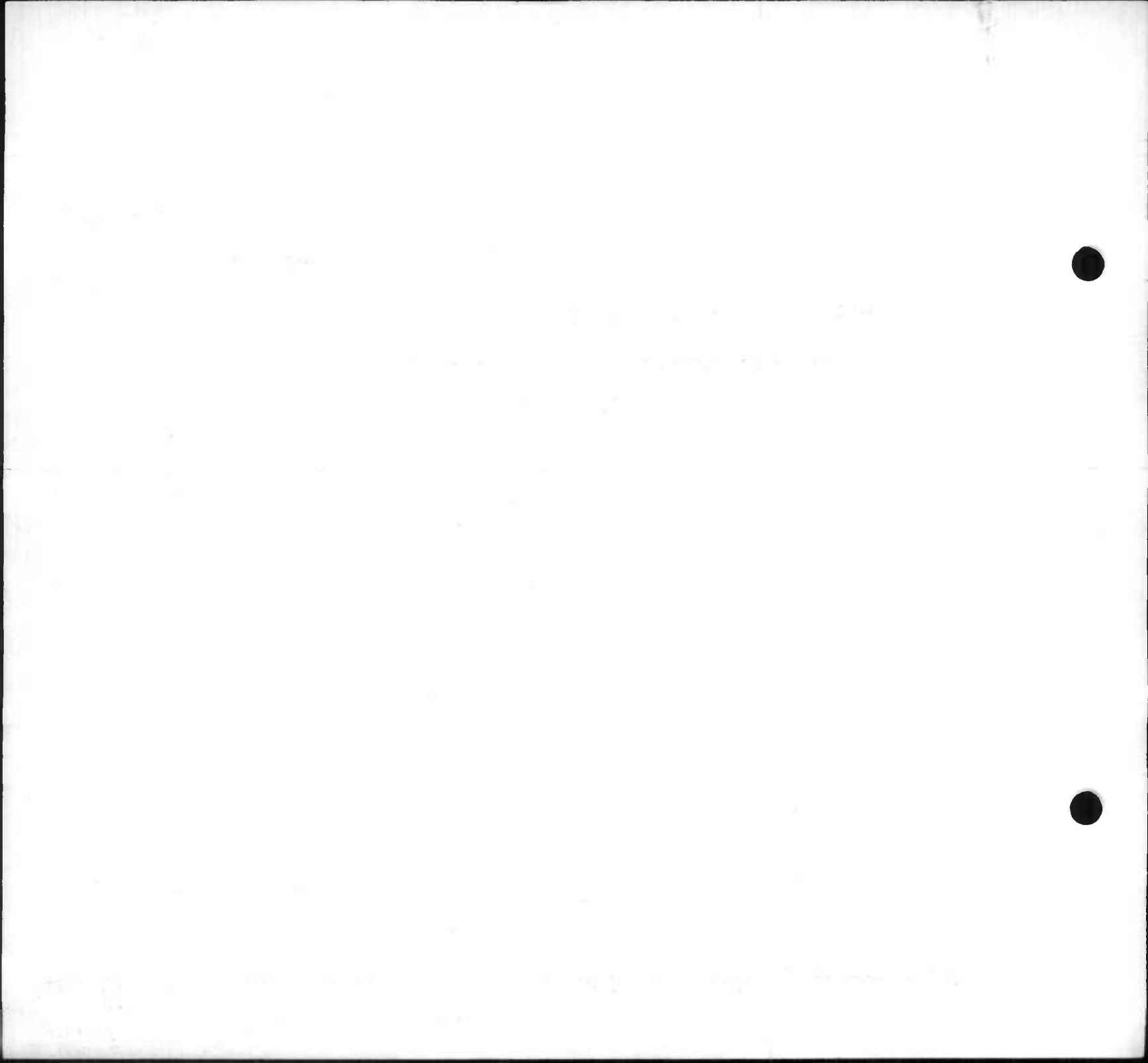
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8638</u>	
P-260 <u>71 8638</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Alfred L. Pekar</u>		2. DATE AND HOUR OF DEATH <u>9/12/71</u> <u>8:15 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>6935 Falkirk Rd</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucas</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/07</u>	9. AGE (in years last birthday) <u>64</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>MICHAEL PEKAR</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-8891</u>		17. INFORMANT <u>Two John Esler - 434 Randon Rd</u>	
18. <u>14507 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration Pneumonia</u> (B) <u>Squamous Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Oral Cavity</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>7/16/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Same</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> 19 <u>71</u> to <u>9/12</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/12</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis A. Shapitz</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/12/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Louis A. Shapitz</u>		23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-15-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Abt. Strickland</u>	
24D. LOCATION <u>Baltimore</u>		24E. LOCATION (City, town, or county) <u>Trif.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>R. E. Gable, R.D.</u>		25C. FUNERAL DIRECTOR <u>Harley Shavannah F.H.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

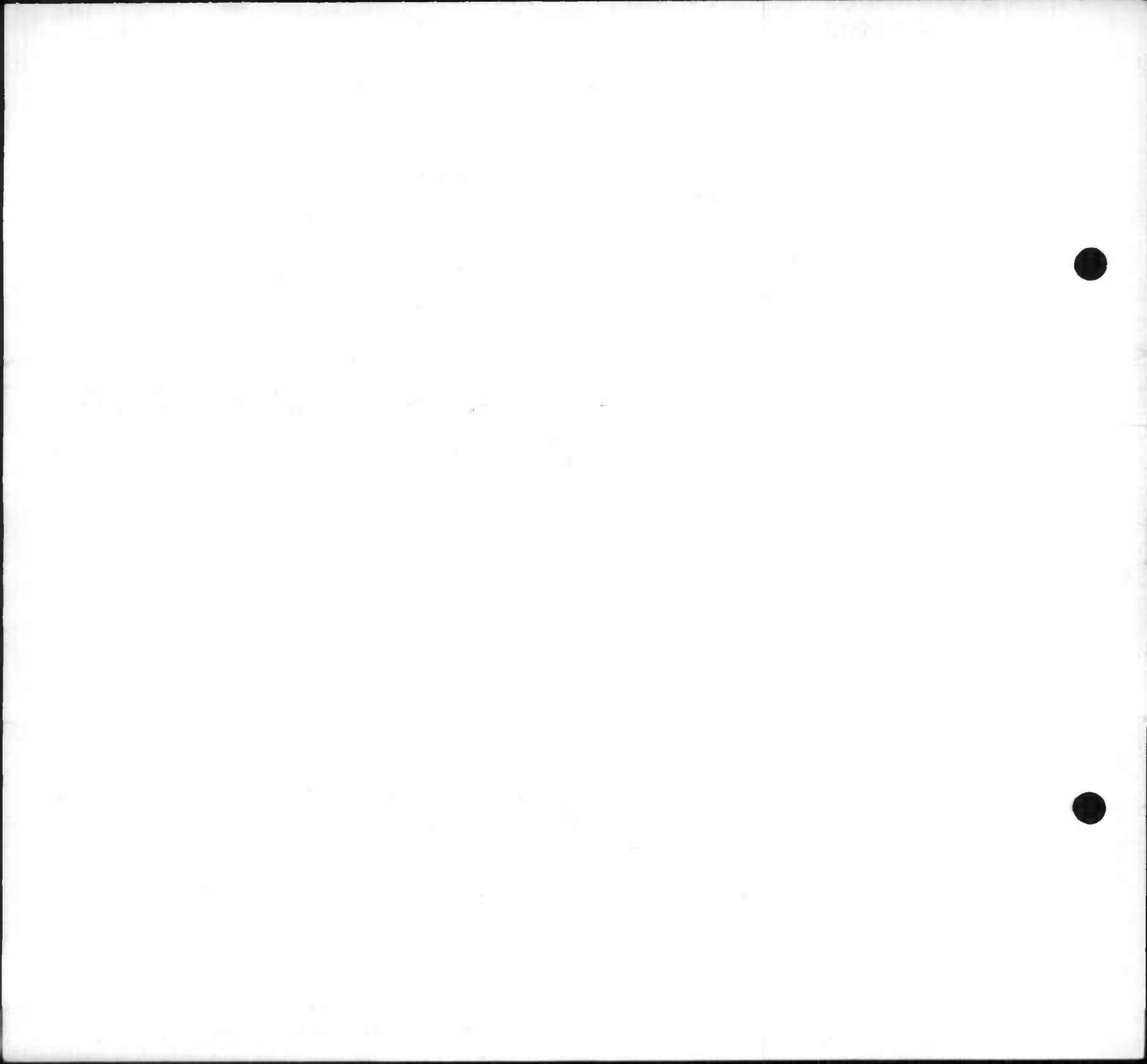
<div style="font-size: 2em; font-weight: bold;">P-520</div> <div style="font-size: 1.5em; font-weight: bold;">71 8639</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO.</div> <div style="font-size: 1.5em; font-weight: bold;">71 8639</div>	
<div style="font-weight: bold; font-size: 0.8em;">BIRTH NO.</div> <div style="font-weight: bold; font-size: 0.8em;">1. NAME OF DECEASED (Type or Print)</div> <div style="font-size: 1.2em;">Edward W. Pence</div>		<div style="font-weight: bold; font-size: 0.8em;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 1.2em;">9-12-71 5:30 AM</div>			
<div style="font-weight: bold; font-size: 0.8em;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div style="font-weight: bold; font-size: 0.8em;">FULL NAME OF HOSPITAL OR INSTITUTION</div> <div style="font-size: 1.2em;">Maryland General Hospital</div>		<div style="font-weight: bold; font-size: 0.8em;">4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div style="font-weight: bold; font-size: 0.8em;">A. STATE</div> <div style="font-size: 1.2em;">Md</div>		<div style="font-weight: bold; font-size: 0.8em;">B. COUNTY</div> <div style="font-size: 1.2em;">908</div>	
<div style="font-weight: bold; font-size: 0.8em;">IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</div> <div style="font-size: 1.2em;">Greenmount Ave Baltimore 2239</div>		<div style="font-weight: bold; font-size: 0.8em;">C. CITY OR TOWN</div> <div style="font-size: 1.2em;">Baltimore</div>		<div style="font-weight: bold; font-size: 0.8em;">D. INSIDE CITY LIMITS?</div> <div style="font-size: 1.2em;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>	
<div style="font-weight: bold; font-size: 0.8em;">5. SEX</div> <div style="font-size: 1.2em;">M</div>		<div style="font-weight: bold; font-size: 0.8em;">6. RACE</div> <div style="font-size: 1.2em;">W</div>		<div style="font-weight: bold; font-size: 0.8em;">7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div style="font-weight: bold; font-size: 0.8em;">WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></div>	
<div style="font-weight: bold; font-size: 0.8em;">8. DATE OF BIRTH</div> <div style="font-size: 1.2em;">SEP 15 1927</div>		<div style="font-weight: bold; font-size: 0.8em;">9. AGE (In years last birthday)</div> <div style="font-size: 1.2em;">43</div>		<div style="font-weight: bold; font-size: 0.8em;">If Under 1 Yr. Months Days</div> <div style="font-weight: bold; font-size: 0.8em;">If Under 24 Hrs. Hours Min.</div>	
<div style="font-weight: bold; font-size: 0.8em;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div style="font-size: 1.2em;">TYPE SETTER</div>		<div style="font-weight: bold; font-size: 0.8em;">10B. KIND OF BUSINESS OR INDUSTRY</div> <div style="font-size: 1.2em;">PRINTING OFFICE</div>		<div style="font-weight: bold; font-size: 0.8em;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-size: 1.2em;">Va.</div>	
<div style="font-weight: bold; font-size: 0.8em;">12. CITIZEN OF WHAT COUNTRY?</div> <div style="font-size: 1.2em;">USA</div>		<div style="font-weight: bold; font-size: 0.8em;">13. FATHER'S NAME</div> <div style="font-size: 1.2em;">DAVID WALTON PENCE</div>		<div style="font-weight: bold; font-size: 0.8em;">14. MOTHER'S MAIDEN NAME</div> <div style="font-size: 1.2em;">CORDIE RAY EPPORD</div>	
<div style="font-weight: bold; font-size: 0.8em;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-size: 1.2em;">?</div>		<div style="font-weight: bold; font-size: 0.8em;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 1.2em;">226-24-3500</div>		<div style="font-weight: bold; font-size: 0.8em;">17. INFORMANT</div> <div style="font-size: 1.2em;">P.H.S. Personal papers</div>	
<div style="font-weight: bold; font-size: 0.8em;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 1.2em;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-size: 1.2em;">1. Cerebral edema and congestion</div>		<div style="font-weight: bold; font-size: 0.8em;">CAUSE OF DEATH</div> <div style="font-size: 1.2em;">(A) IMMEDIATE CAUSE</div> <div style="font-size: 1.2em;">2. Pulmonary edema + congestion</div>		<div style="font-weight: bold; font-size: 0.8em;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div style="font-size: 1.2em;">3 1/2 days</div>	
<div style="font-weight: bold; font-size: 0.8em;">ANTECEDENT CAUSES</div> <div style="font-size: 1.2em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div style="font-size: 1.2em;">(B) DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-size: 1.2em;">(C) Cardiopulmonary arrest - resuscitation</div>		<div style="font-size: 1.2em;">Anoxia severe</div> <div style="font-size: 1.2em;">3 1/2 days</div>		<div style="font-size: 1.2em;">3 1/2 days</div>	
<div style="font-weight: bold; font-size: 0.8em;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div> <div style="font-size: 1.2em;">Chronic Alcoholism - Acute Alcoholism</div>					
<div style="font-weight: bold; font-size: 0.8em;">19A. DATE OF OPERATION</div> <div style="font-size: 1.2em;">9-12-71</div>		<div style="font-weight: bold; font-size: 0.8em;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div style="font-size: 1.2em;">-</div>		<div style="font-weight: bold; font-size: 0.8em;">20A. AUTOPSY? (Yes or No)</div> <div style="font-size: 1.2em;">YES</div>	
<div style="font-weight: bold; font-size: 0.8em;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> <div style="font-size: 1.2em;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div style="font-weight: bold; font-size: 0.8em;">21C. WHERE DID INJURY OCCUR?</div> <div style="font-size: 1.2em;">(If in Baltimore City, give exact location)</div>		<div style="font-weight: bold; font-size: 0.8em;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> <div style="font-size: 1.2em;">N.</div>	
<div style="font-weight: bold; font-size: 0.8em;">21D. TIME OF INJURY (Approx.)</div> <div style="font-size: 1.2em;">(Month) (Day) (Year) (Hour)</div>		<div style="font-weight: bold; font-size: 0.8em;">21E. INJURY OCCURRED</div> <div style="font-size: 1.2em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<div style="font-weight: bold; font-size: 0.8em;">21F. HOW DID INJURY OCCUR?</div> <div style="font-size: 1.2em;">-</div>	
<div style="font-weight: bold; font-size: 0.8em;">22. I certify that (I) (this hospital) attended the deceased from 9-8 19 71 to 9-12 19 71</div> <div style="font-weight: bold; font-size: 0.8em;">that (I) (we) last saw the deceased alive on 9-12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div style="font-weight: bold; font-size: 0.8em;">23A. SIGNATURE</div> <div style="font-size: 1.2em;">Arnold G. Alexander MD</div>		<div style="font-weight: bold; font-size: 0.8em;">23B. DATE SIGNED</div> <div style="font-size: 1.2em;">9-12-71</div>		<div style="font-weight: bold; font-size: 0.8em;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em;">Arnold G. Alexander MD</div>	
<div style="font-weight: bold; font-size: 0.8em;">23D. ADDRESS</div> <div style="font-size: 1.2em;">MGH</div>		<div style="font-weight: bold; font-size: 0.8em;">23E. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em;">Arnold G. Alexander MD</div>		<div style="font-weight: bold; font-size: 0.8em;">23F. ADDRESS</div> <div style="font-size: 1.2em;">MGH</div>	
<div style="font-weight: bold; font-size: 0.8em;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 1.2em;">REMOVAL/BURIAL</div>		<div style="font-weight: bold; font-size: 0.8em;">24B. DATE</div> <div style="font-size: 1.2em;">9/14/71</div>		<div style="font-weight: bold; font-size: 0.8em;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-size: 1.2em;">LAKEVIEW CEMT.</div>	
<div style="font-weight: bold; font-size: 0.8em;">24D. LOCATION (City, town, or county)</div> <div style="font-size: 1.2em;">BLACKSTONE (NOTTOWAY) VA.</div>		<div style="font-weight: bold; font-size: 0.8em;">24E. DATE REC'D BY HEALTH DEPT</div> <div style="font-size: 1.2em;">SEP 15 1971</div>		<div style="font-weight: bold; font-size: 0.8em;">24F. NAME OF REGISTRAR</div> <div style="font-size: 1.2em;">HARDIN F. HONE</div>	
<div style="font-weight: bold; font-size: 0.8em;">24G. DATE REC'D BY HEALTH DEPT</div> <div style="font-size: 1.2em;">SEP 15 1971</div>		<div style="font-weight: bold; font-size: 0.8em;">24H. NAME OF REGISTRAR</div> <div style="font-size: 1.2em;">HARDIN F. HONE</div>		<div style="font-weight: bold; font-size: 0.8em;">24I. FUNERAL DIRECTOR</div> <div style="font-size: 1.2em;">BLACKSTONE, VA.</div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

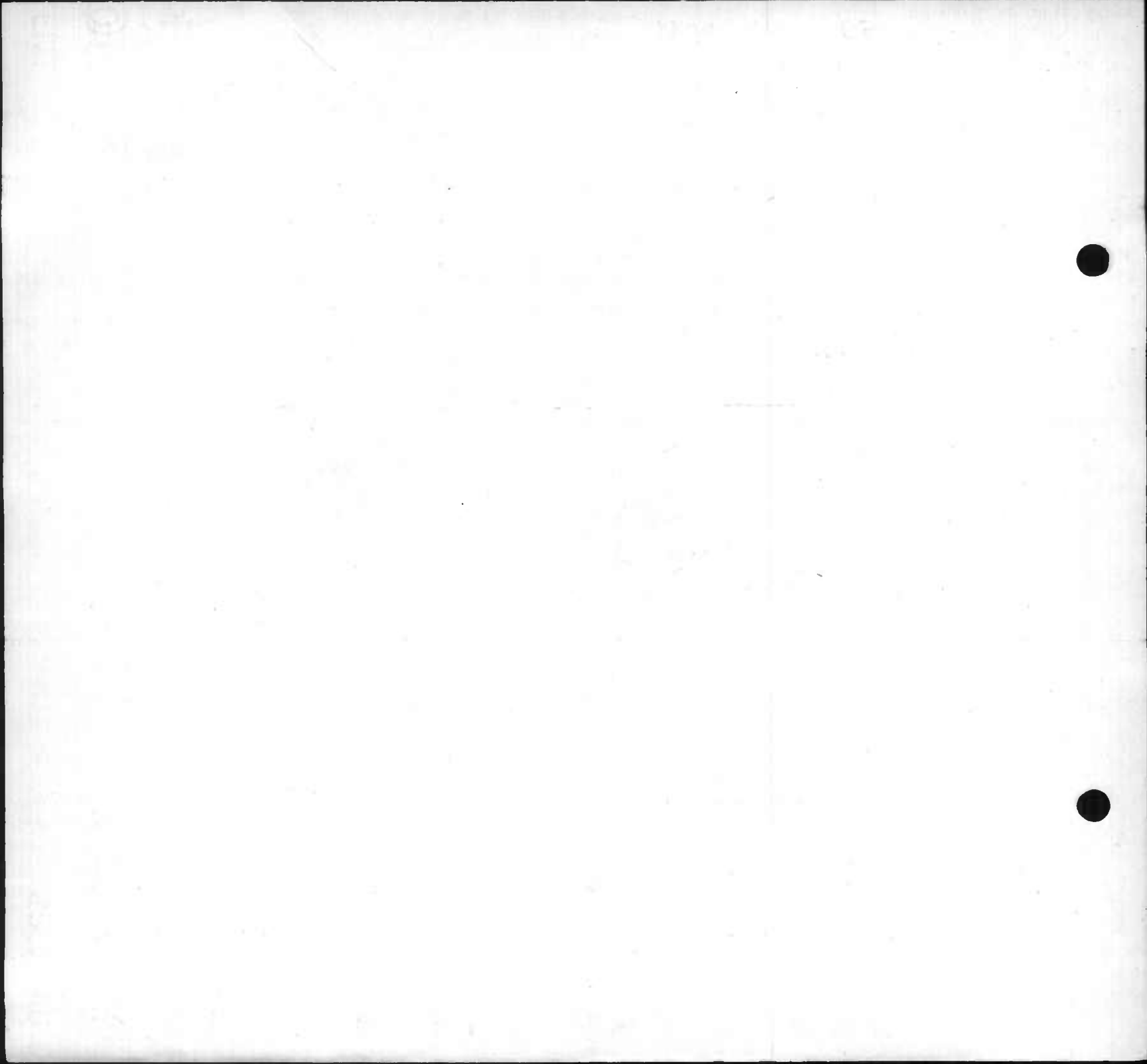
G-240 71 8640		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8640	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Frances E. Gogel			2. DATE AND HOUR OF DEATH September 10, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 2800 Whitney Avenue Baltimore, Maryland 21215			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female			6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Aug. 15, 1883		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13. FATHER'S NAME Adrian H. Fitzpatrick			14. MOTHER'S MAIDEN NAME Margaret E. McCormick		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) None			16. SOCIAL SECURITY NO. 217016-1704		
			17. INFORMANT Mrs. Frances E. Gogel 2800 Whitney Ave. Baltimore, Md. 21215		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Arteriosclerotic cardiovascular disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary emphysema</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i> <i>Several years</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 23</i> 19 <i>71</i> to <i>Sept 10</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Aug 23</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Seymour H. Rubin</i>			23B. DATE SIGNED 9/11/71		
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin			23D. ADDRESS 5415 Park Heights Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/13/1971		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Woodlawn, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133 <i>Loring Byers Funeral Directors, P. A.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-650 71 8641				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8641	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Louis R. Kern Sr.		Friday Sept. 10, 71 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Sinai, Hospital of Baltimore				Maryland		2740	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				6101 Stuart Ave. 21209			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 22, 1911		59		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Automotive Supply				United Warehouse		Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Henry Kern				Caroline Baum			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				212-09-7081		Mrs. Kathryn Kern-- 6101 Stuart Ave. 21209	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Acute Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from November 20, 1965 to 1971, that (I) (we) last saw the deceased alive on 7-14-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Rafael Perez-Mera Md.						9-13-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				8507 Liberty Rd. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Sept. 13, 71		Parkwood cemetery		Parkville Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 15 1971		Robert E. Fisher, M.D.		Loring, Myers Funeral Directors P.A.		18728 Liberty Rd. Randallstown, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

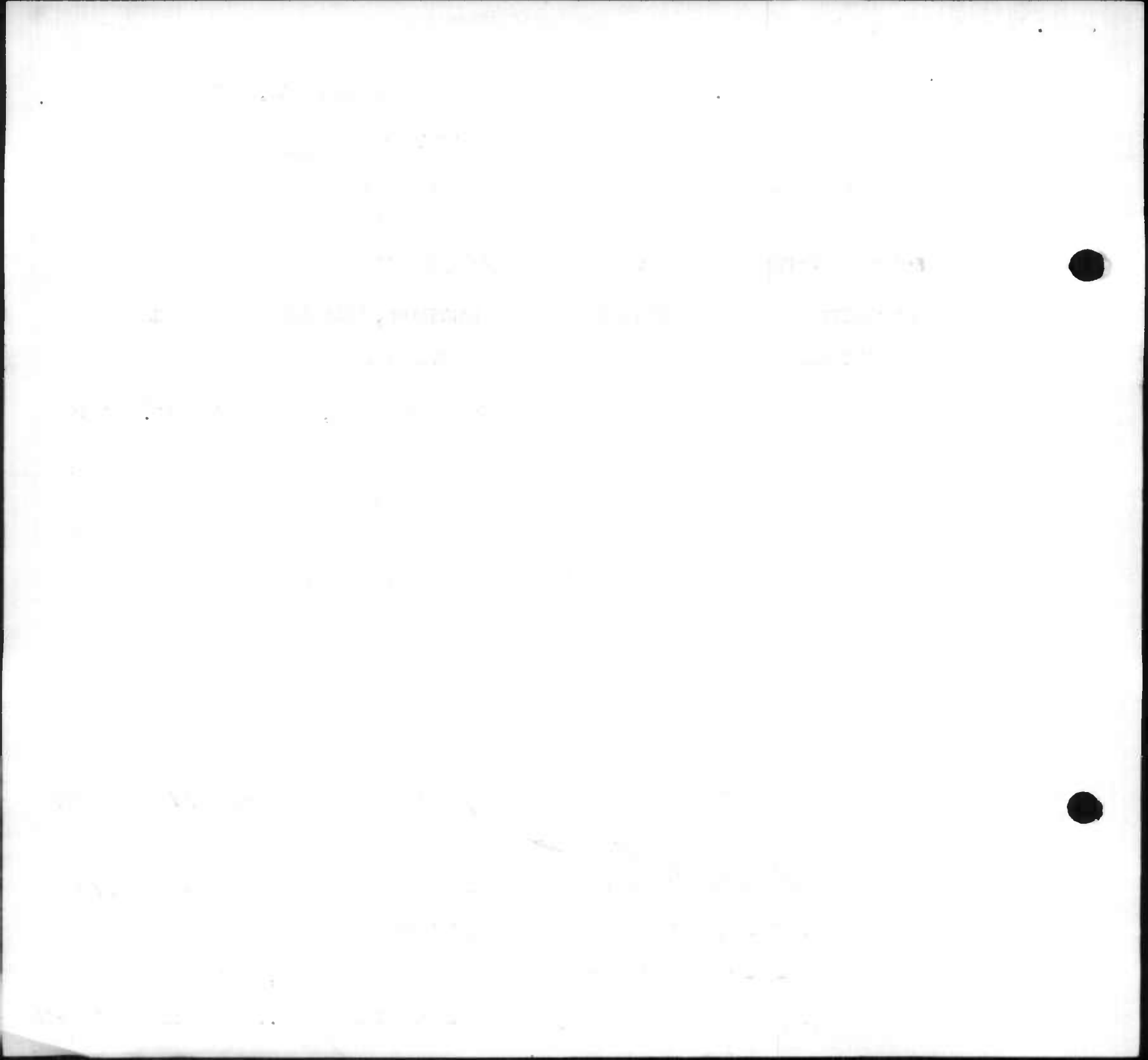
<p>V-320 71 8642</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8642</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) JOSEPH FRANCIS VITEK</p>		<p>2. DATE AND HOUR OF DEATH 9/9/71 6:45 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 38</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE 2631</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 4216 BELMAR AVE.</p>	
<p>5. SEX M</p> <p>6. RACE Caucasian</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11-11-06</p> <p>9. AGE (In years last birthday) 64</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Belmar Pharmacy</p>	<p>11. BIRTHPLACE (State or foreign country) Balto. Md.</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME JOHN VITEK</p>	
<p>14. MOTHER'S MAIDEN NAME Eliz. Cuach</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No</p>	
<p>16. SOCIAL SECURITY NO. 217-03-6349</p>		<p>17. INFORMANT Hosp. CHART</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 213-05-9469 RENAL FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERLEMIA METASTATIC CA OF BLADDER (B) DUE TO, OR AS A CONSEQUENCE OF: (C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 2</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) YES</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 8/24 19 71 to 9/9 19 71 that (I) (we) last saw the deceased alive on 9/9 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Mark H. Kasowitz MD</p>		<p>23B. DATE SIGNED 9/9/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) MARK H. KASOWITZ</p>		<p>23D. ADDRESS UNIV. HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 9-13-71</p>	<p>24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial</p>	<p>24D. LOCATION (City, town, or county) Cockeysville Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971</p>	<p>25B. NAME OF REGISTRAR Robert E. Taylor, Md.</p>	<p>25C. FUNERAL DIRECTOR John G. Boller Inc. 6415 Belair Rd. 21225</p>	<p>ADDRESS</p>

17-51-3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8643		
BIRTH NO. <div style="font-size: 2em; float: left; margin-right: 10px;">M-460</div> <div style="font-size: 2em; float: left; margin-right: 10px;">71</div> <div style="font-size: 2em; float: left;">8643</div>								
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">SADIE F. MILLER</div>				2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">SEPTEMBER 11, 1971</div> <div style="text-align: right; font-size: 2em;">5 A.M.</div>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center; font-size: 1.2em;">5305 NELSON AVENUE</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <div style="text-align: center; font-size: 1.2em;">MARYLAND</div> B. COUNTY <div style="text-align: center; font-size: 2em;">2788</div> C. CITY OR TOWN <div style="text-align: center; font-size: 1.2em;">BALTIMORE</div> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="text-align: center; font-size: 1.2em;">5305 NELSON AVENUE #21215</div>				
5. SEX <div style="text-align: center; font-size: 1.2em;">FEMALE</div>		6. RACE <div style="text-align: center; font-size: 1.2em;">WHITE</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">10-10-1905</div>		
9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">65</div>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">HOUSEWIFE</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">AT HOME</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">BALTIMORE, MARYLAND</div>		
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">USA</div>		13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">HARRY FRANK</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">MARY NITZBERG</div>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center; font-size: 1.2em;">NO</div>		16. SOCIAL SECURITY NO.		17. INFORMANT <div style="text-align: center; font-size: 1.2em;">MISS LITA MILLER, 5305 NELSON AVE. #21215</div>				
18. CAUSE OF DEATH <div style="text-align: center; font-size: 1.2em;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <p style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <div style="text-align: center; font-size: 1.2em;">ANTECEDENT CAUSES</div> <p style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				(A) IMMEDIATE CAUSE <div style="text-align: center; font-size: 1.2em;">Heart failure</div> DUE TO, OR AS A CONSEQUENCE OF: (B) HABIT <div style="text-align: center; font-size: 1.2em;">HABIT</div> DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus, obesity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 1.2em;">Sudden</div> <div style="text-align: center; font-size: 1.2em;">years</div>		
<div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center; font-size: 1.2em;">19 56</div> 19 <div style="text-align: center; font-size: 1.2em;">Sept 10</div> 19 <div style="text-align: center; font-size: 1.2em;">71</div> that (I) (we) last saw the deceased alive on <div style="text-align: center; font-size: 1.2em;">Sept 10</div> 19 <div style="text-align: center; font-size: 1.2em;">71</div> and that in (my) (our) opinion death occurred on the date <div style="text-align: center; font-size: 1.2em;">Sept 11</div> and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <div style="text-align: center; font-size: 1.2em;">Joseph C. Matchar</div>				23B. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">9/11/71</div>		23C. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">JOSEPH MATCHAR</div>		
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">BURIAL</div>		24B. DATE <div style="text-align: center; font-size: 1.2em;">9-12-71</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center; font-size: 1.2em;">MIKRO KODESH</div>		24D. LOCATION (City, town, or county) (State) <div style="text-align: center; font-size: 1.2em;">BALTIMORE, MARYLAND</div>		
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center; font-size: 1.2em;">SEP 15 1971</div>		25B. NAME OF REGISTRAR <div style="text-align: center; font-size: 1.2em;">Robert E. Talley, M.D.</div>		25C. FUNERAL DIRECTOR <div style="text-align: center; font-size: 1.2em;">SOL LEVINSON & BROS.</div>		ADDRESS <div style="text-align: center; font-size: 1.2em;">6010 REISTERSTOWN ROAD</div>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-341 71 8644		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8644	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Adleberg, Louis</u>		2. DATE AND HOUR OF DEATH <u>9/10/71</u> <u>10⁰⁰ P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland, Baltimore</u> B. COUNTY <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp. Inc of Baltimore</u>		E. STREET AND NUMBER <u>6934 Glenheights Ave. 21215</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/89</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN ADLEBERG</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>		17. INFORMANT <u>Lillian Adleberg</u> ADDRESS <u>6934 Glenheights Rd.</u>	
18. <u>73691</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral - vascular accident</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/10/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>71</u> to <u>8/10</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>8/10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jack Pollack</u>		23B. DATE SIGNED <u>9/10/71</u>		23C. PHYSICIAN'S NAME (Type) <u>JACK POLLACK</u>	
23D. ADDRESS <u>SINAI HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-12-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fabel</u>		25C. FUNERAL DIRECTOR <u>SOUL LEVINSON & BROS.</u>		ADDRESS <u>6010 REISTERSTOWN ROAD</u>	

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William Campbell

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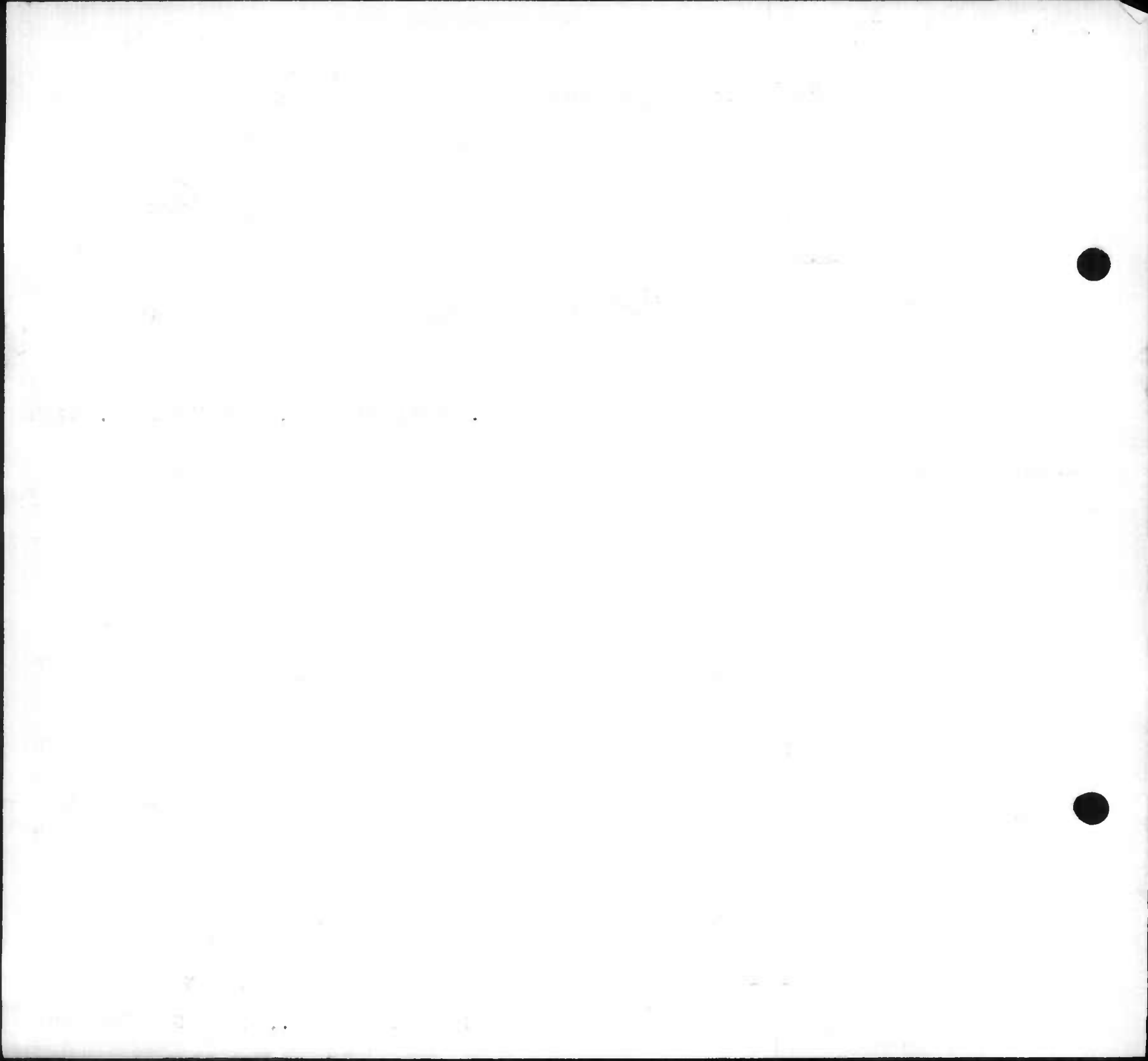
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8/10/11

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

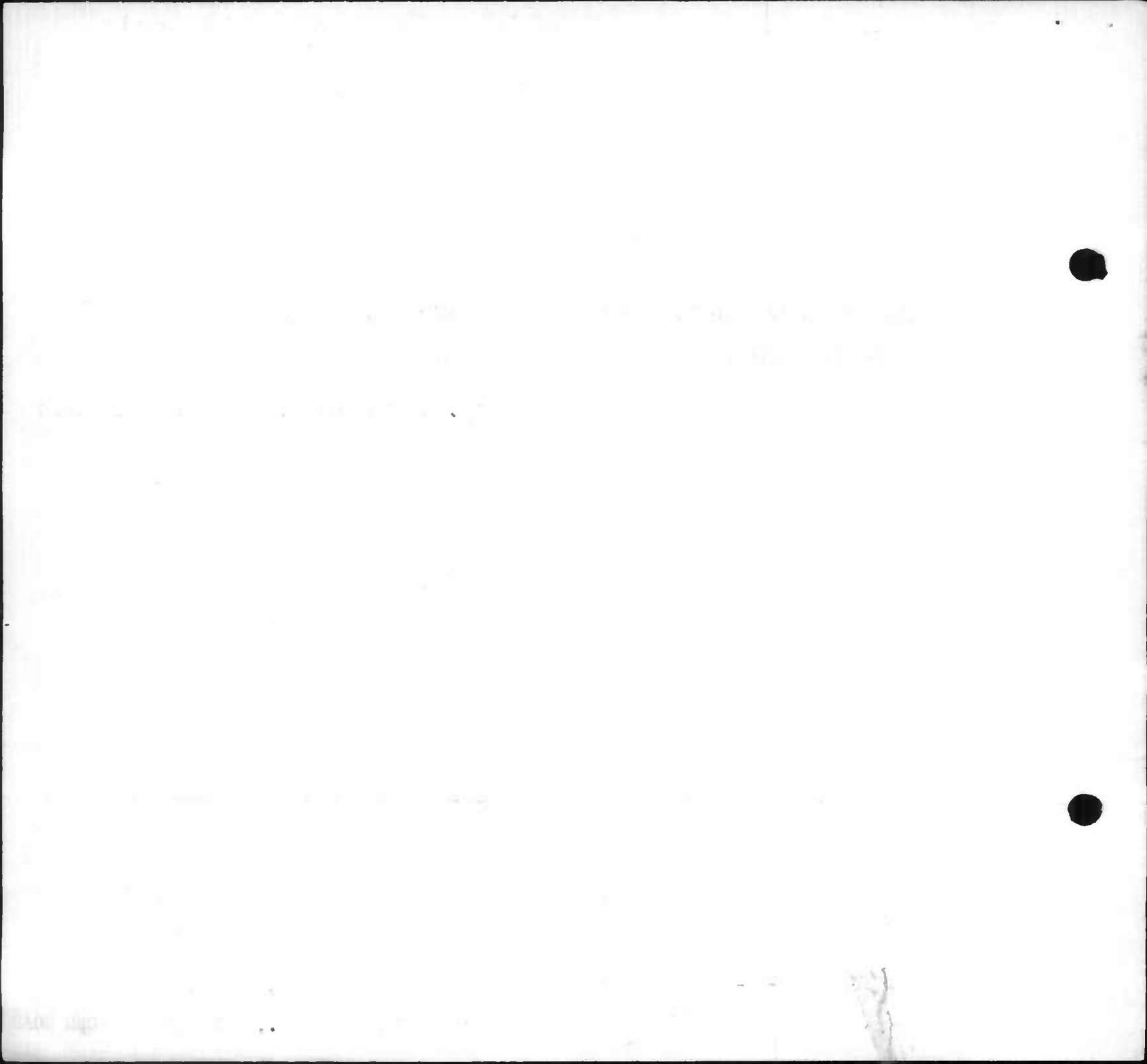
N-252 71 8645		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8645	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) XXXX MANYA Nechamkin		2. DATE AND HOUR OF DEATH 9/10/71 1:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2720			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in the Pines - Belvedere 2525 West Belvedere Balto., Md. 21215		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/19/97		9. AGE (In years last birthday) 74		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Israel Krinitzky		14. MOTHER'S MAIDEN NAME Rissie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. ISRAEL NECHAMKIN, 2418 SYLVALE RD. #21209	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Inanition Metastatic carcinoma of the colon (B) Pneumonia, heart failure, pulmonary emboli? DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week several months? several weeks several months?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8/17/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal mass		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from about 1965 to 9/10/71 that (I) (we) last saw the deceased alive on 9/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Gerald N. Maggid, M.D.		23B. DATE SIGNED 9/10/71		23C. PHYSICIAN'S NAME (Type) Gerald N. Maggid, M.D.	
23D. ADDRESS Pikesville Medical Center Pikesville, Md. 21208					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-12-71		24C. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK	
24D. LOCATION RANDALLSTOWN, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

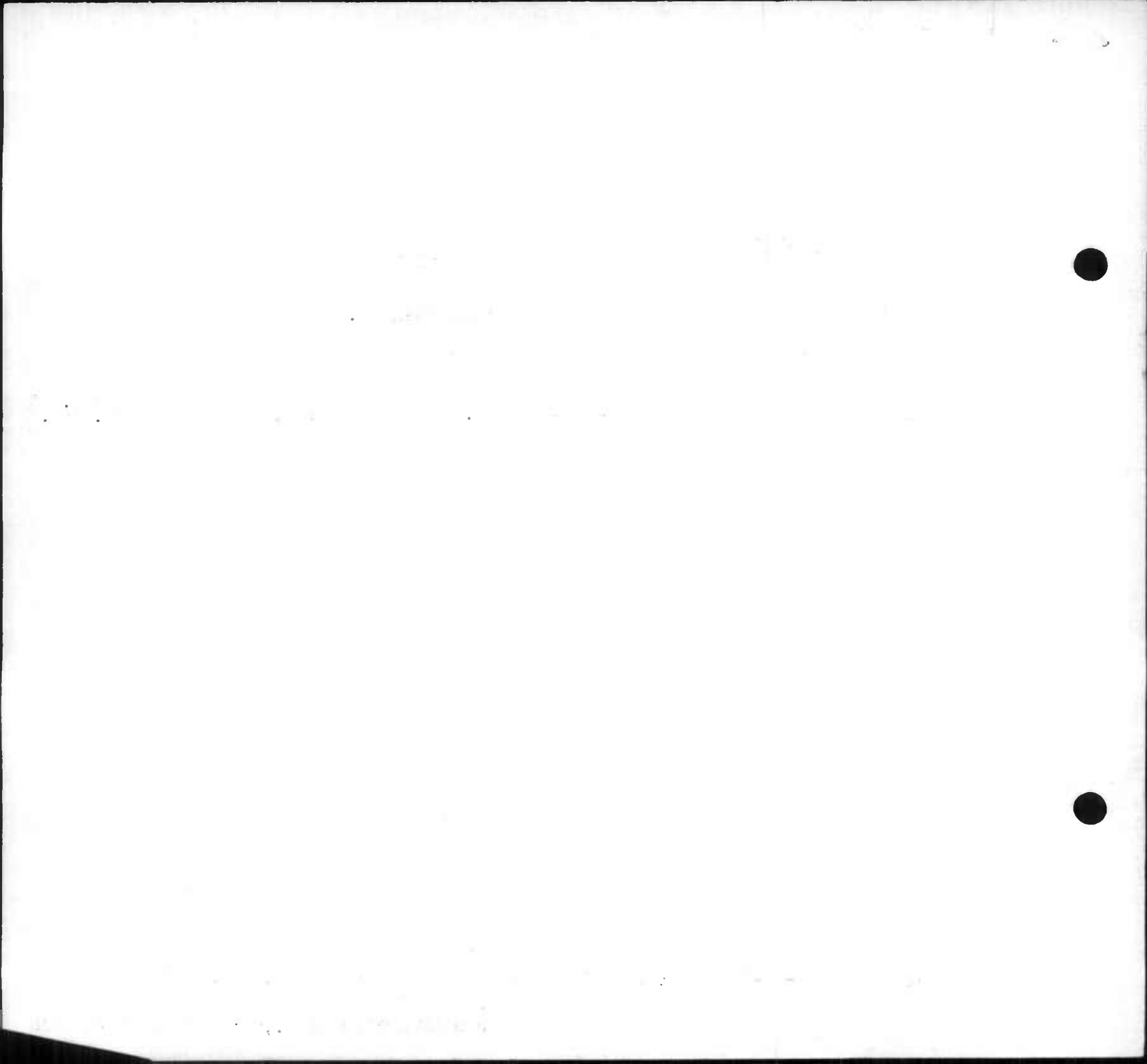
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 8646	
BIRTH NO. 5-230 71 8646		CERTIFICATE OF DEATH X	
1. NAME OF DECEASED (Type or Print) Mr. David Schochet		2. DATE AND HOUR OF DEATH 9/10/71 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 5300	
5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/26/15	
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXXSELF EMPLOYED GROCER	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH SCHOCHET		14. MOTHER'S MAIDEN NAME ANNA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ELSIE SCHOCHET, 3415 KELOX ROAD #21207		ADDRESS	
18. I 23071 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 9/10/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Sept 10 1971 to Sept 10 1971 and that (I) (we) last saw the deceased alive on Sept 10 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Michael A. Silverman MD 23B. DATE SIGNED 9/10/71 23C. PHYSICIAN'S NAME (Type) Michael A. Silverman MD 23D. ADDRESS Maryland General Hosp. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 9-12-71 24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE 24D. LOCATION BALTIMORE, MARYLAND 25A. DATE REC'D BY HEALTH DEPT SEP 15 1971 25B. NAME OF REGISTRAR Robert E. Sabin, M.D. 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

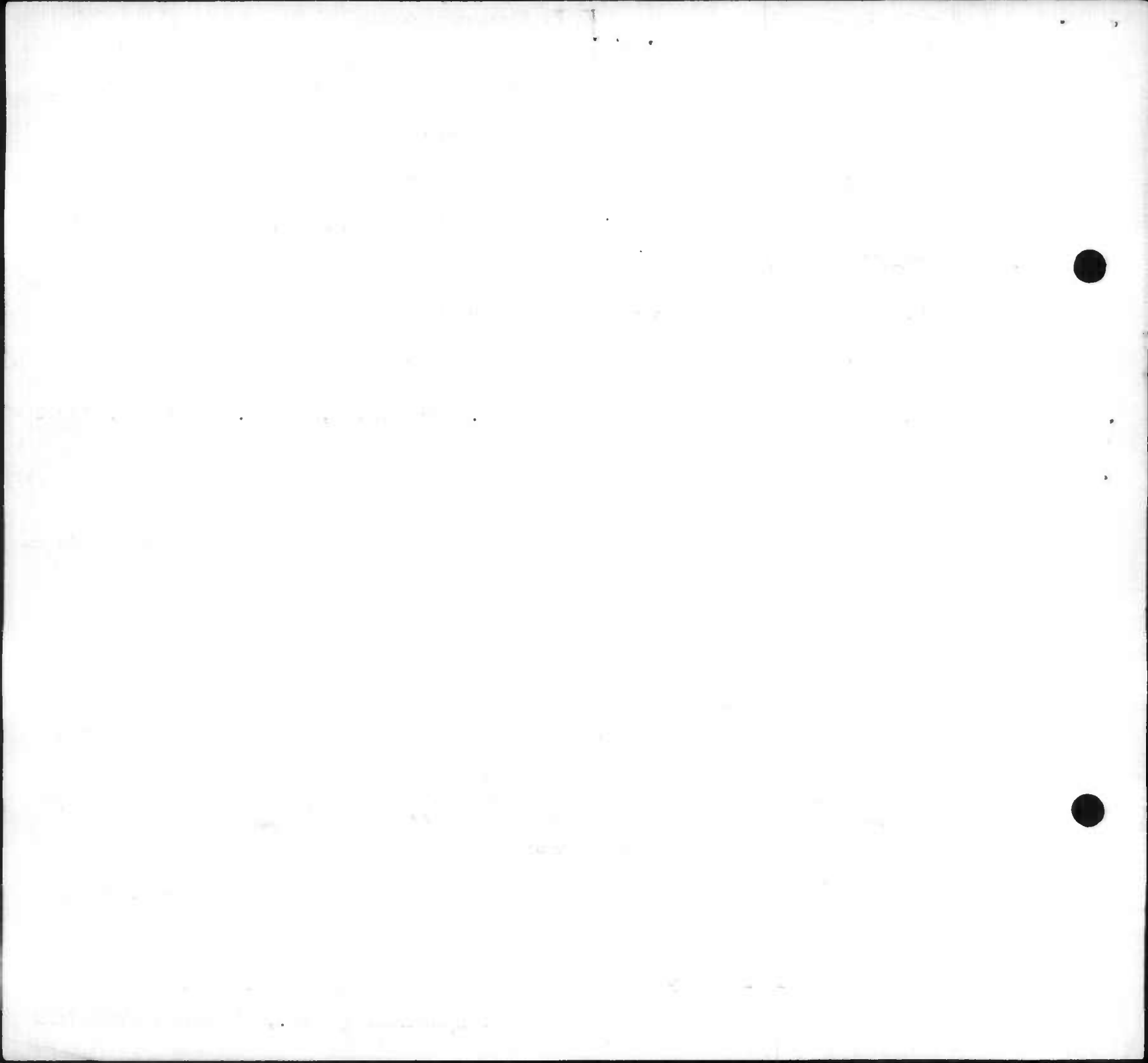
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8647
BIRTH NO. 71 8647		1. NAME OF DECEASED (Type or Print) APPLEFELD, THERESA		
2. DATE AND HOUR OF DEATH September 12, 1971 6:00 AM.		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore Inc. Belvedere Ave at Greenspring.		A. STATE Maryland B. COUNTY 2730		
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 7121 Park Hghts Ave #15				
5. SEX female	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/1929	9. AGE (in years last birthday) 41
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME SIMON LEVIN		14. MOTHER'S MAIDEN NAME ANNIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-48-7553		17. INFORMANT MR. SAMUEL APPLEFELD, 7121 PARK HIGHTS. AVE.
18. CAUSE OF DEATH		ADDRESS APT. 808		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) brain ca metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE adenocarcinoma uteri		
(B) _____		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED total hysterectomy for ca		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 30 1971 to September 12 1971 that (I) (we) last saw the deceased alive on September 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Z. Kalisky		23B. DATE SIGNED 9/12/71		
23C. PHYSICIAN'S NAME (Type) Z. KALISKY		23D. ADDRESS Sinai Hospital of Baltimore MD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOH LEVINSON & BROS., 6010 REISTERSTOWN
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

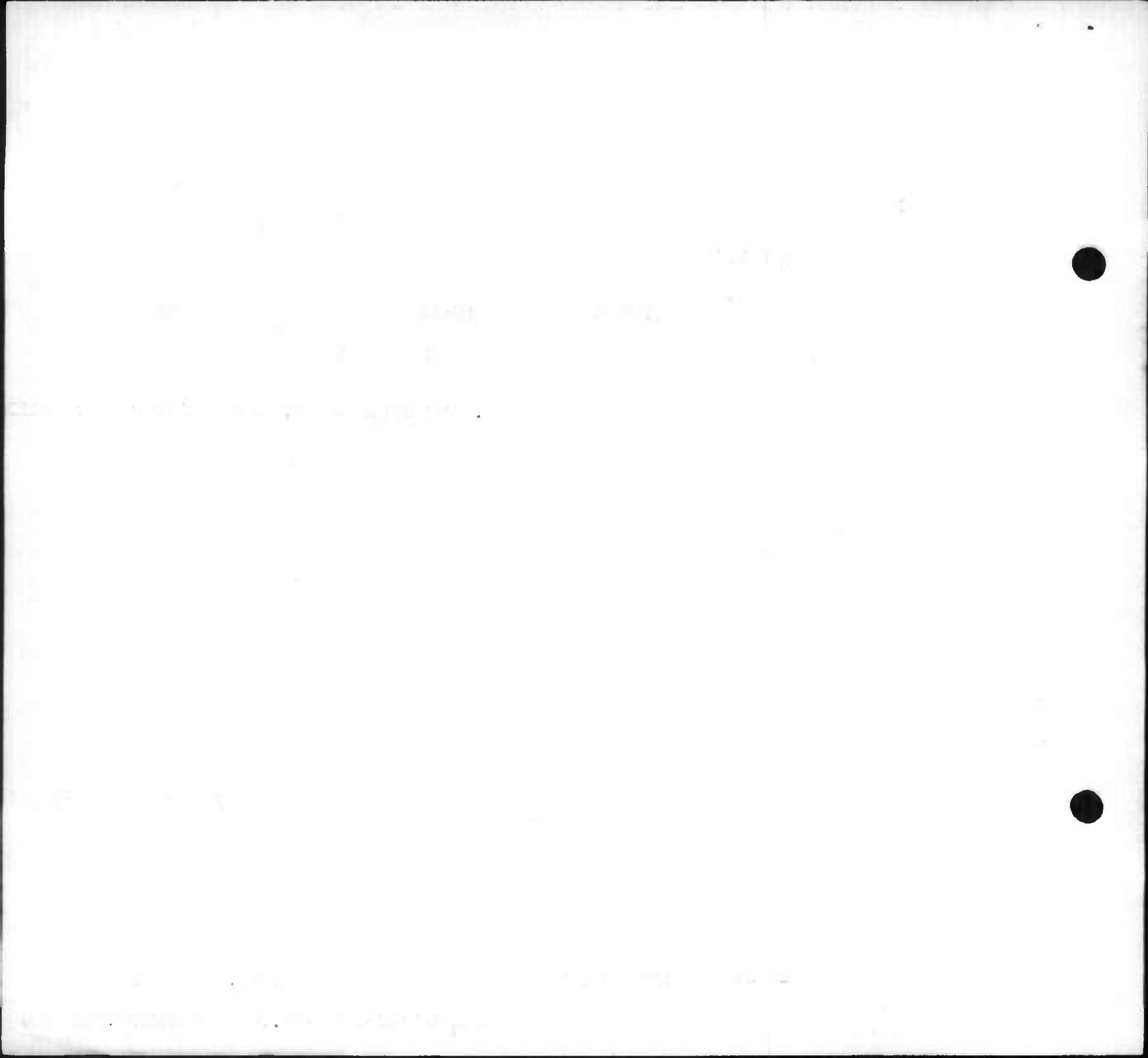
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8648	
<div style="display: flex; justify-content: space-between;"> J-525 71 8648 </div>							
BIRTH NO. 1. NAME OF DECEASED (Type or Print) SARAH INKMAN				2. DATE AND HOUR OF DEATH 9-12-71 1630/A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL 42				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3922 CLARINTH ROAD			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN BART				14. MOTHER'S MAIDEN NAME SARAH ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MR. HARRY KRUGER, 326 ST. PAUL PLACE, #21202 ADDRESS	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days 27 days </div> </div>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 8-17-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HIP		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NURSING HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) MILFORD MANOR NURSING HOME		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-16-71 9AM	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PT. FELL					
22. I certify that (this hospital) attended the deceased from 8-16 19 71 to 9-12 19 71 that (I) last saw the deceased alive on 9-11 19 71 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view the body after death).							
23A. SIGNATURE Ronald P. Byank, M.D.				23B. DATE SIGNED 9-12-71		23C. PHYSICIAN'S NAME (Type) RONALD P. BYANK, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME OF CEMETERY OR CREMATORY N CHIZUK AMUNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



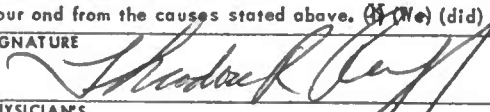
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-251 71 8649 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8649	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) EISENBERG, FANNIE		2. DATE AND HOUR OF DEATH 9/11/71 8:47 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 42		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2509 FARRINGTON Rd.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/1904 9. AGE (In years last birthday) 67 If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HYMAN BROOKS		14. MOTHER'S MAIDEN NAME ROSE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____ 17. INFORMANT MR. SAMUEL EISENBERG, 2509 FARRINGTON ROAD #212 ADDRESS _____	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) VENTRICULAR FIBRILLATION CONG. HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS CVD CA of the LUNG		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 8/30 19 71 to 9/11 19 71 that (I) (we) last saw the deceased alive on 9/11/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Annette T. Ordway, Jr.		23B. DATE SIGNED 9/11/71	
23C. PHYSICIAN'S NAME (Type) ANNETTE T. ORDWAY, JR., M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71	
24C. NAME OF CEMETERY OR CREMATORY LIBERTY PARK		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robt. E. Johnson	
25C. FUNERAL DIRECTOR SON LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8650</u>	
BIRTH NO. <u>C-500 71 8650</u>					
1. NAME OF DECEASED (Type or Print) <u>Elsie Cohen</u> (ELKA)		2. DATE AND HOUR OF DEATH <u>9-12-1971</u> <u>3:20</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Levindale Hebrew Geriatric Center and Hospital (Chronic Disease Hospital area)</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u>			
5. SEX <u>Female</u>		6. RACE <u>Human</u> <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		8. DATE OF BIRTH <u>7-18-1904</u>	
13. FATHER'S NAME <u>LAZER LAPIN</u>		14. MOTHER'S MAIDEN NAME <u>CHANA LEAHM ?</u>		9. AGE (In years last birthday) <u>80</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>HANNAH SAMORODIN 6310 GREENSPRING AVE APT 306</u>	
18. <u>445, 10 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Emboli (?septic) days/weeks</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus, Arteriosclerotic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>months</u> <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <u>II</u>					
19A. DATE OF OPERATION <u>August 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrene left foot</u>		20A. AUTOPSY? (Yes or No) <u>Limited Post</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3-20</u> <u>19 68</u> to <u>9-12</u> <u>19 71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9-12</u> <u>19 71</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <u>9-12-1971</u>		23C. PHYSICIAN'S NAME (Type) <u>Theodore R. Reiff, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/12/71</u>		24C. NAME of CEMETERY or CREMATORY <u>GREATER HALTO LODGE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS 6010 REISTERSTOWN ROAD</u>	
24D. LOCATION <u>BOWLEYS LANE</u>		24E. ADDRESS <u>LEVINSALE HEBREW HOME W. BELVEDERE AVENUE</u>			

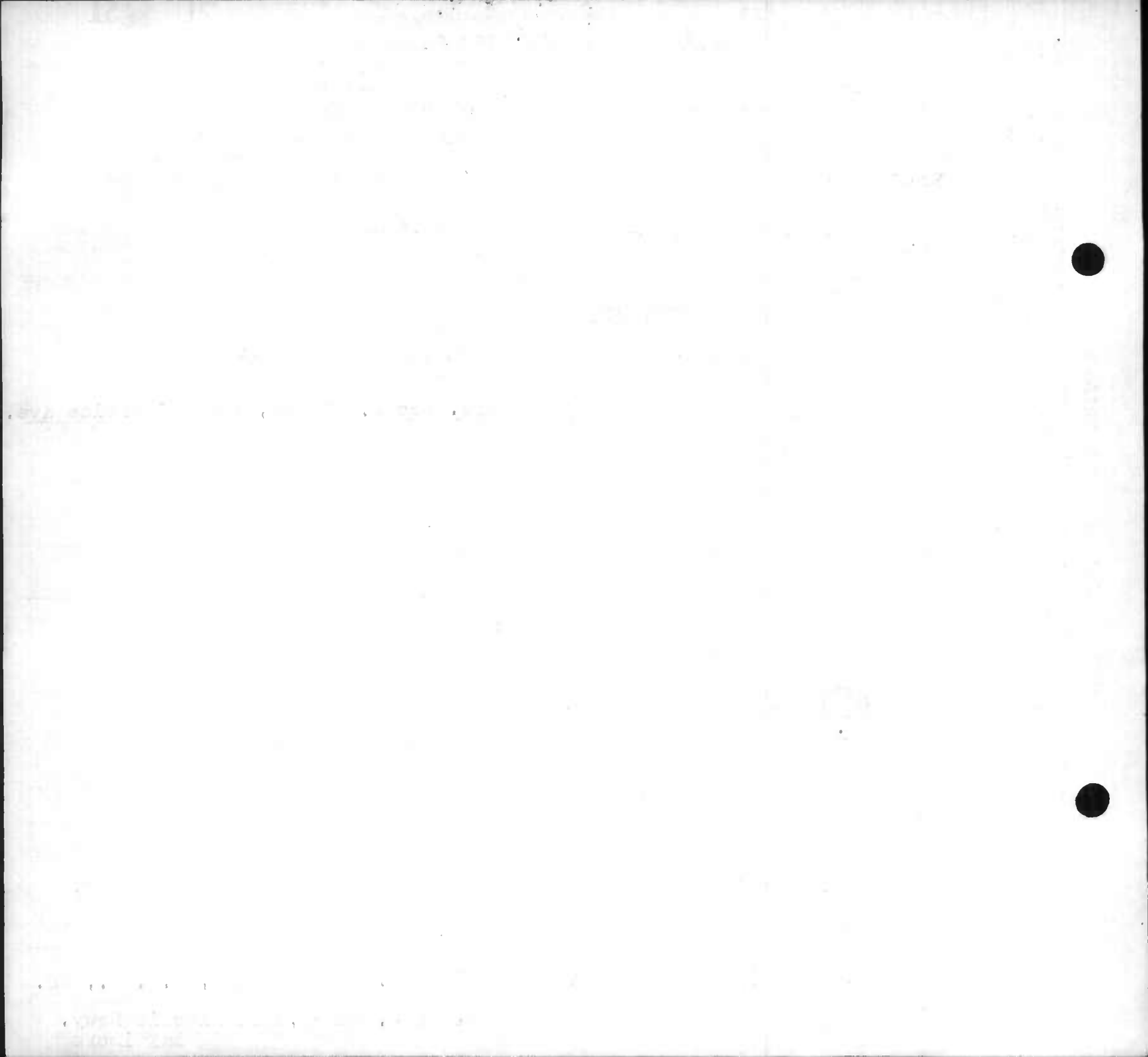
Adm. 3/20/68

5410 Reisterstown Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 8651
W-450 71 8651		REG. NO. _____
CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Leo James Whalen</u>		2. DATE AND HOUR OF DEATH <u>Sept. 9, 1971</u> <u>11:00 A.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH Baltimore General Hospital</u> <u>43</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1296 Riverside Ave.</u>
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>10/9/1920</u>		9. AGE (In years last birthday) <u>50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>American Rescue Service (Handyman)</u>		10B. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas E. Whalen</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Taylor</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 07 9437</u>
17. INFORMANT <u>Mrs. Leo J. Whalen, 1296 Riverside Ave.</u>		ADDRESS _____
18. <u>162-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Ca of Lung</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____ (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>D</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH _____
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that the (this hospital) attended the deceased from <u>Aug. 26</u> 19 <u>71</u> to <u>Sept. 9</u> 19 <u>71</u> that the (we) last saw the deceased alive on <u>Sept. 9</u> 19 <u>71</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Chiu Sung Chan</u> M.D. DEGREE		23B. DATE SIGNED <u>Sept. 9, 71</u>
23C. PHYSICIAN'S NAME (Type) <u>Chiu Sung Chan</u> DEGREE		23D. ADDRESS <u>South Baltimore General Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/13/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Pk.</u>
24D. LOCATION (City, town, or county) (State) <u>G1 en Burnie, A.A.Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>George J. Gons</u>
25D. ADDRESS <u>3,4001 Ritchie Hgwy.</u>		<u>Baltimore</u>



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 8652**

BIRTH NO. **H-220**

1. NAME OF DECEASED (Type or Print) B. Juanita Hughes		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 10, 1971 Hour 8:00 PM	
4. PLACE OF DEATH (If in Baltimore, give street address or location) South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1971 8:06 PM	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2534	
9. DATE OF BIRTH Nov. 19, 1918		10. AGE (In years lost birthday) 52 51	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		14B. KIND OF BUSINESS OR INDUSTRY Restaurant	
15. MOTHER'S MAIDEN NAME Nora Myrtle Sparks		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 452 36 0516		18. INFORMANT ADDRESS Evan Hughes (same)	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshotwound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9/14/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) Sept. 10, 71 8:00 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? bedroom of 3900 5th Street		22F. HOW DID INJURY OCCUR? shot self in head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED September 11, 1971 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71	
24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robert E. Naylor, M.D.	
25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy.		ADDRESS Baltimore, Md.	

VS 151-REV. 1/1/68

V.S. 153 9-20-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

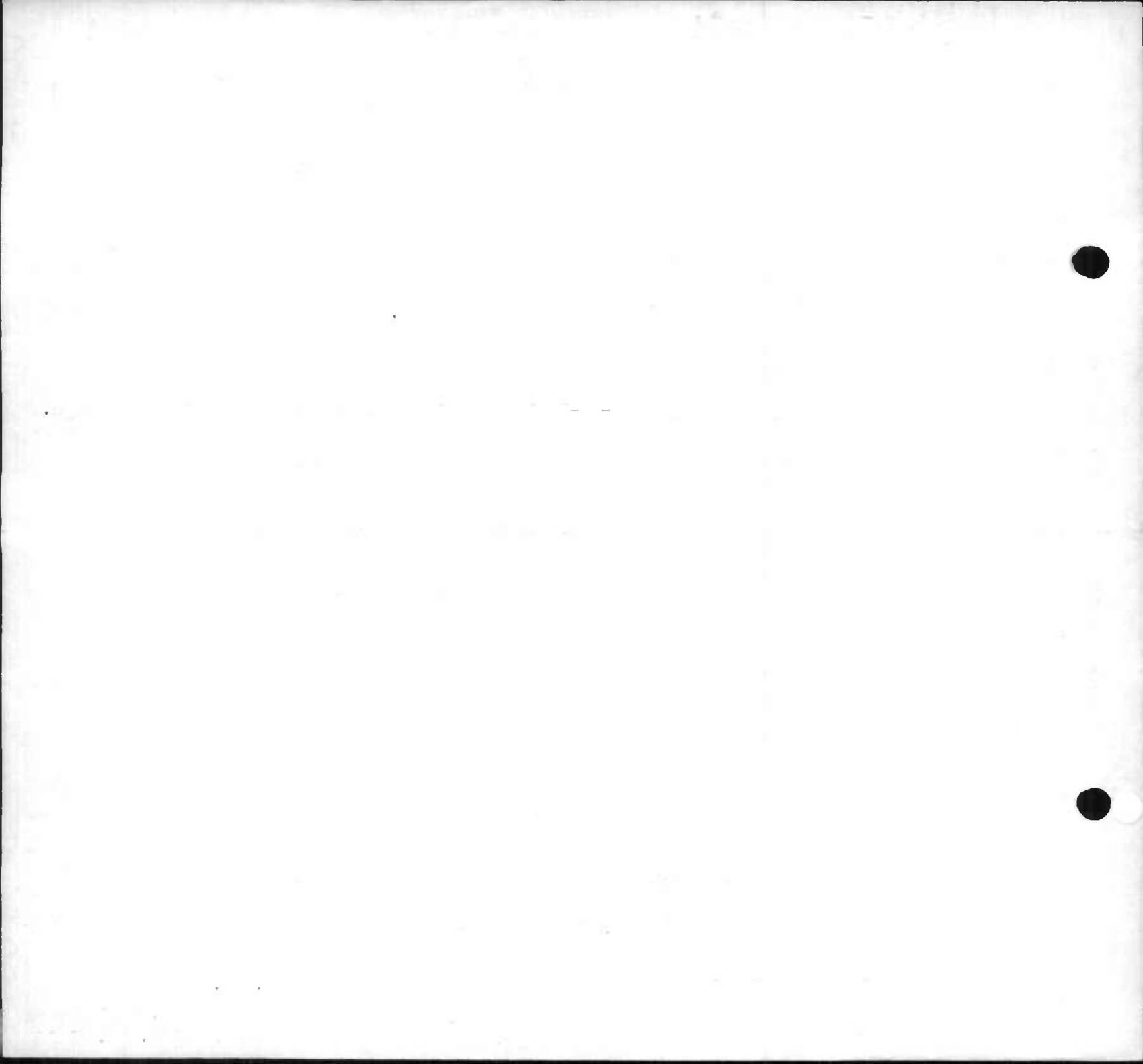
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8653	
S-60071 8653			
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) SAWYER, T. EDGAR		9-11-71 900/pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BAL	
FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		C. CITY OR TOWN ELICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 4209 CREST PLACE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RET.	9. AGE (in years last birthday) 72
11. BIRTHPLACE (State or foreign country) MARYLAND-USA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL SAWYER		14. MOTHER'S MAIDEN NAME BARRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-8197	17. INFORMANT HOSP. REC. ADDRESS
18. 412.41 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Uremia	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) CHF 2 ASCVD	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
(C) -			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 9-11-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 days		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-8 1971 to 9-11 1971 that (I) (we) last saw the deceased alive on 9-11 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Somchai Werasophon MD		23B. DATE SIGNED 9-11-71	
23C. PHYSICIAN'S NAME (Type) SOMCHAI WERASOPHON MD		23D. ADDRESS BON. SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/15/71	
24C. NAME OF CEMETERY OR CREMATORY CRESTLAWN		24D. LOCATION (City, town, or county) (State) HOWARD CO. MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR John E. Jaber, MD	
25C. FUNERAL DIRECTOR McKAB		ADDRESS 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

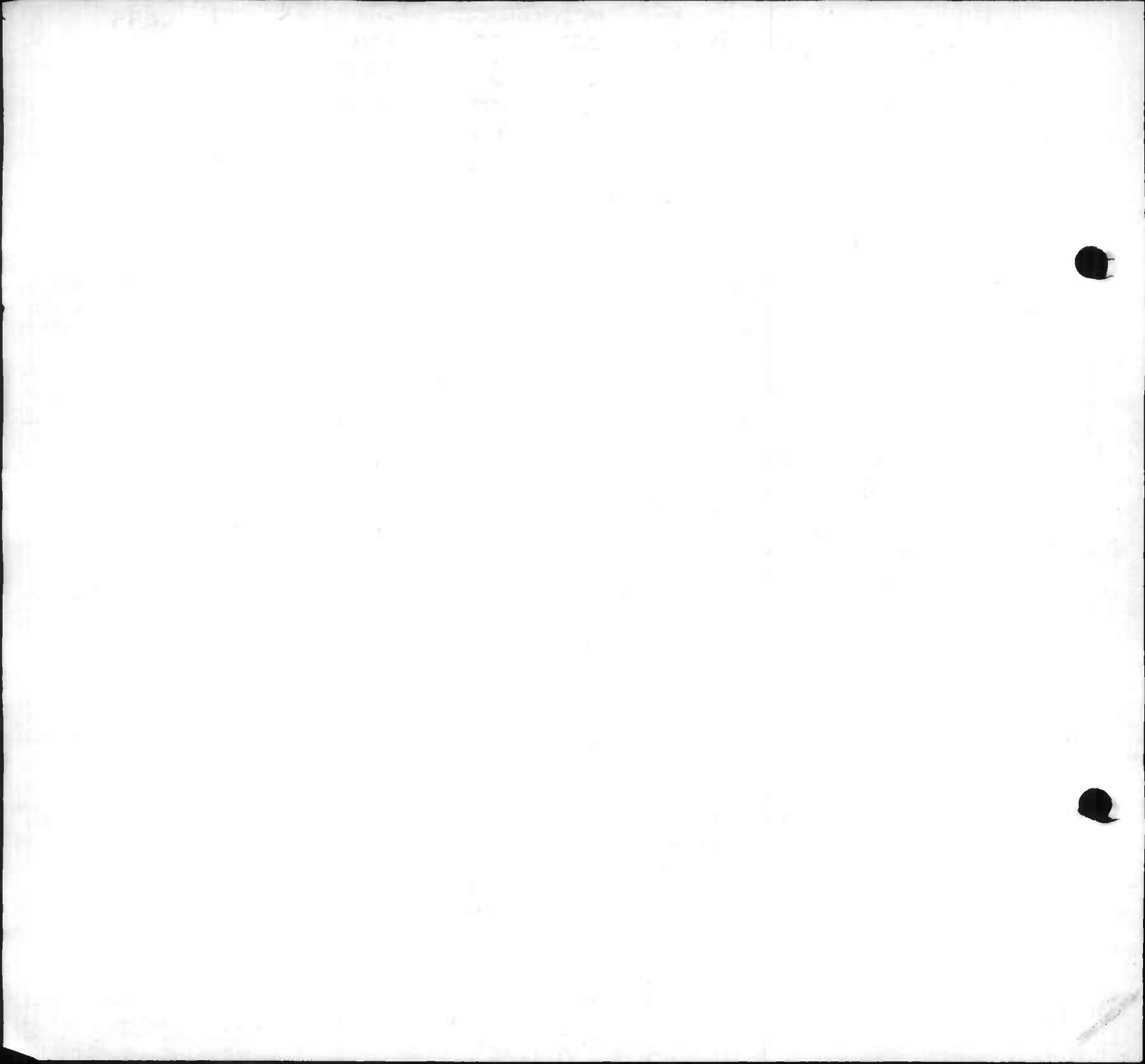
<h2 style="margin: 0;">Baltimore City Health Department</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <u>71 8654</u>	
BIRTH NO. <u>S-350 71 8654</u>		2. DATE AND HOUR OF DEATH <u>9-12-1971 8.05 PM.</u>	
1. NAME OF DECEASED (Type or Print) <u>SUTTON ROSE ANN</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2642</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>4217 MORAVIA ROAD</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TYPIST</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>WILLIAM E. SUTTON</u>		14. MOTHER'S MAIDEN NAME <u>ALICE JOHNSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-36-1521</u>	
17. INFORMANT <u>Charles Sutton (brother)</u>		ADDRESS <u>1217 Moravia Rd.</u>	
18. <u>74761</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>NEUROGENIC SHOCK</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CEREBRO VASCULAR ACCIDENT</u> <u>CONGENITAL ANEURYSM</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCUR?</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>9-12-71 (3pm) 1971</u> to <u>9-12-71 8.05 PM 1971</u> that (I) (we) last saw the deceased alive on <u>9-12-71 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Jose Paz</u>		23B. DATE SIGNED <u>9-12-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSE PAZ</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>9/16/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>John E. Miller</u>	
25C. FUNERAL DIRECTOR <u>Schumacher Funeral Homes, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

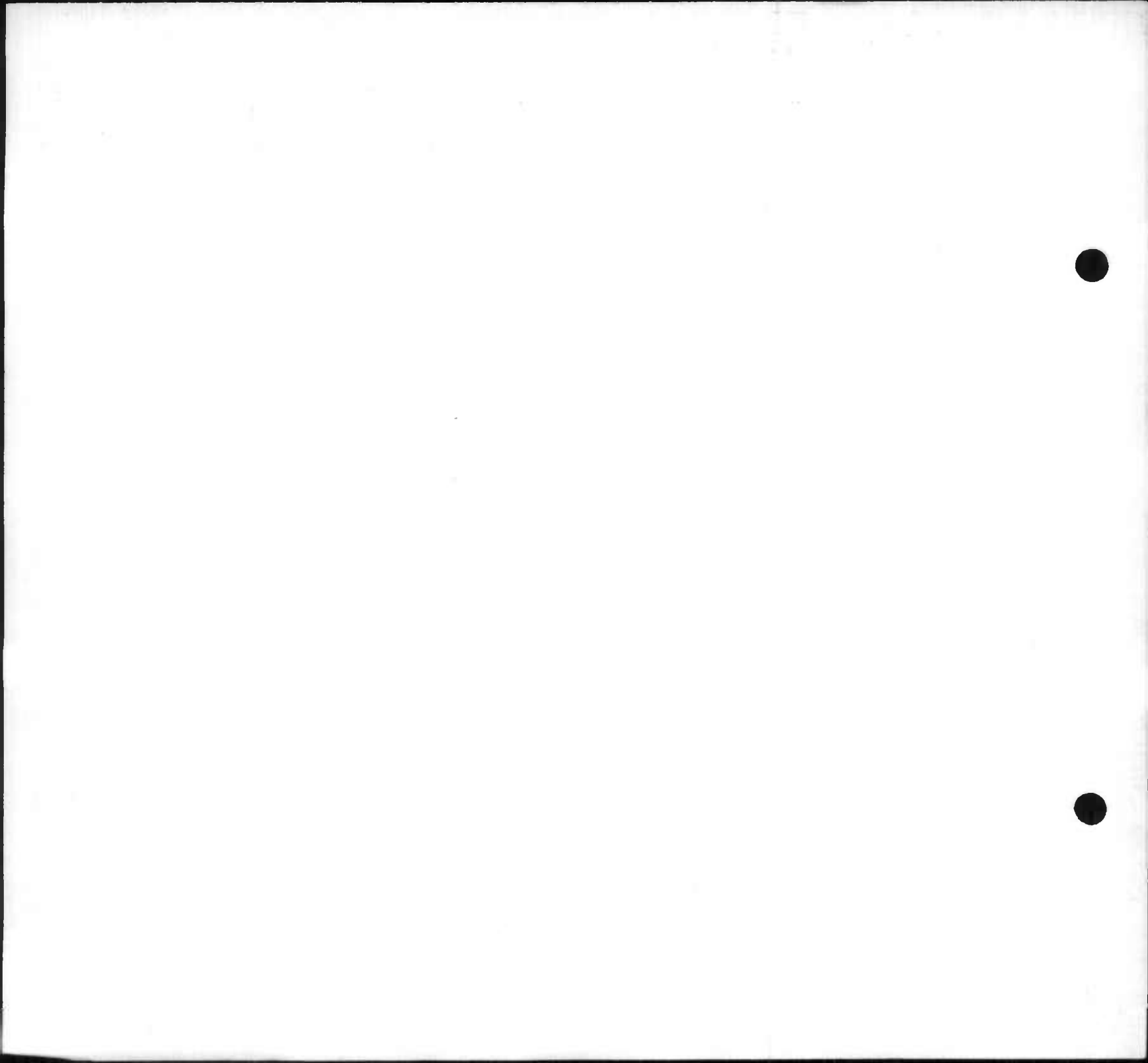
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8655	
L-163 71 8655		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANTHONY J. LIBERTINE		2. DATE AND HOUR OF DEATH 9.12.71 10:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL BALTIMORE MD 21231		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 203	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OWNER		E. STREET AND NUMBER 734 S. BROADWAY	
10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2.12.25	9. AGE (In years last birthday) 46
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA.	
13. FATHER'S NAME JOSEPH LIBERTINE		14. MOTHER'S MAIDEN NAME ROSE CZINA (CUCINA)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 911 190311	
17. INFORMANT Prabir K Bose		ADDRESS Church Home and Hospital	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ? MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEME	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). G.I. BLEEDING		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		_____	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9.10. 19 71 to 9.12 19 71 that (I) (we) last saw the deceased alive on 9.12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Prabir K. Bose MD		23B. DATE SIGNED 9.12.71	
23C. PHYSICIAN'S NAME (Type) PRAABIR K. BOSE MD		23D. ADDRESS Church Home and Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9.16.71	
24C. NAME OF CEMETERY OR CREMATORY Holy Trinity Russian Orth. Cem.		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR J. C. [unclear]	
25C. FUNERAL DIRECTOR Jefferson St.		ADDRESS 2334	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 71 8656		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8656	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Bernard J. Lease Sr.		9/14/71 11 40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Bon Secours Hospital 34 2025 W. Fayette Baltimore, M.D.			509 LaClaire Ave Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Lith. M.D.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			509 LaClaire Avenue 21090		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
M	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/9/23	48 yrs	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Counter man		Sanitary Plumbing		Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Lease			Maudie Nicholson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		215-12-8297		Mrs. Bernard Lease 509 LaClaire Ave. 21090	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES			Active portal cirrhosis		?
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Alcoholism		years
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Relief from hepatic encephalopathy		days
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9-7-71		Abdominal mass		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
				In Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8-31-71 to 9-14-71 that (I) (we) last saw the deceased alive on 9-14-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Thien Thivara M.D.			9/14/71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Thien Thivara M.D.			Bon Secours Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/17/71		New Cathedral	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 15 1971		Robert E. Salter, M.D.		Witzke, 1630 Edmondson Avenue 21228	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Irving V. Queen		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 8, 1971 ? M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2202 N. Calvert Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1971 6:20 PM M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/2/02		10. AGE (In years last birthday) 69	
11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME DENNIS QUEEN		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1204	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 705-09-9489		18. INFORMANT EVA QUEEN	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED September 11, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/16/71	
24C. NAME OF CEMETERY OR CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTO, MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR 1971000	
25C. FUNERAL DIRECTOR Margaret R Brown		ADDRESS 3106 Walkbrook Lane	

THE FOLLOWING IS A LIST OF THE LANDS BELONGING TO THE UNITED STATES

IN THE TERRITORY OF ARIZONA

AS OF THE 1ST DAY OF JANUARY 1839

THE LANDS ARE CLASSIFIED AS FOLLOWS:

1. LANDS BELONGING TO THE UNITED STATES

2. LANDS BELONGING TO THE STATE OF ARIZONA

3. LANDS BELONGING TO THE COUNTY OF COCHISE

4. LANDS BELONGING TO THE COUNTY OF COCONINO

5. LANDS BELONGING TO THE COUNTY OF GUADELUPE

6. LANDS BELONGING TO THE COUNTY OF MARICOPA

7. LANDS BELONGING TO THE COUNTY OF MOHAVE

8. LANDS BELONGING TO THE COUNTY OF YAVAPAI

9. LANDS BELONGING TO THE COUNTY OF YAVAPAI

10. LANDS BELONGING TO THE COUNTY OF YAVAPAI

11. LANDS BELONGING TO THE COUNTY OF YAVAPAI

12. LANDS BELONGING TO THE COUNTY OF YAVAPAI

13. LANDS BELONGING TO THE COUNTY OF YAVAPAI

14. LANDS BELONGING TO THE COUNTY OF YAVAPAI

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17. LANDS BELONGING TO THE COUNTY OF YAVAPAI

18. LANDS BELONGING TO THE COUNTY OF YAVAPAI

19. LANDS BELONGING TO THE COUNTY OF YAVAPAI

20. LANDS BELONGING TO THE COUNTY OF YAVAPAI

21. LANDS BELONGING TO THE COUNTY OF YAVAPAI

22. LANDS BELONGING TO THE COUNTY OF YAVAPAI

23. LANDS BELONGING TO THE COUNTY OF YAVAPAI

24. LANDS BELONGING TO THE COUNTY OF YAVAPAI

25. LANDS BELONGING TO THE COUNTY OF YAVAPAI

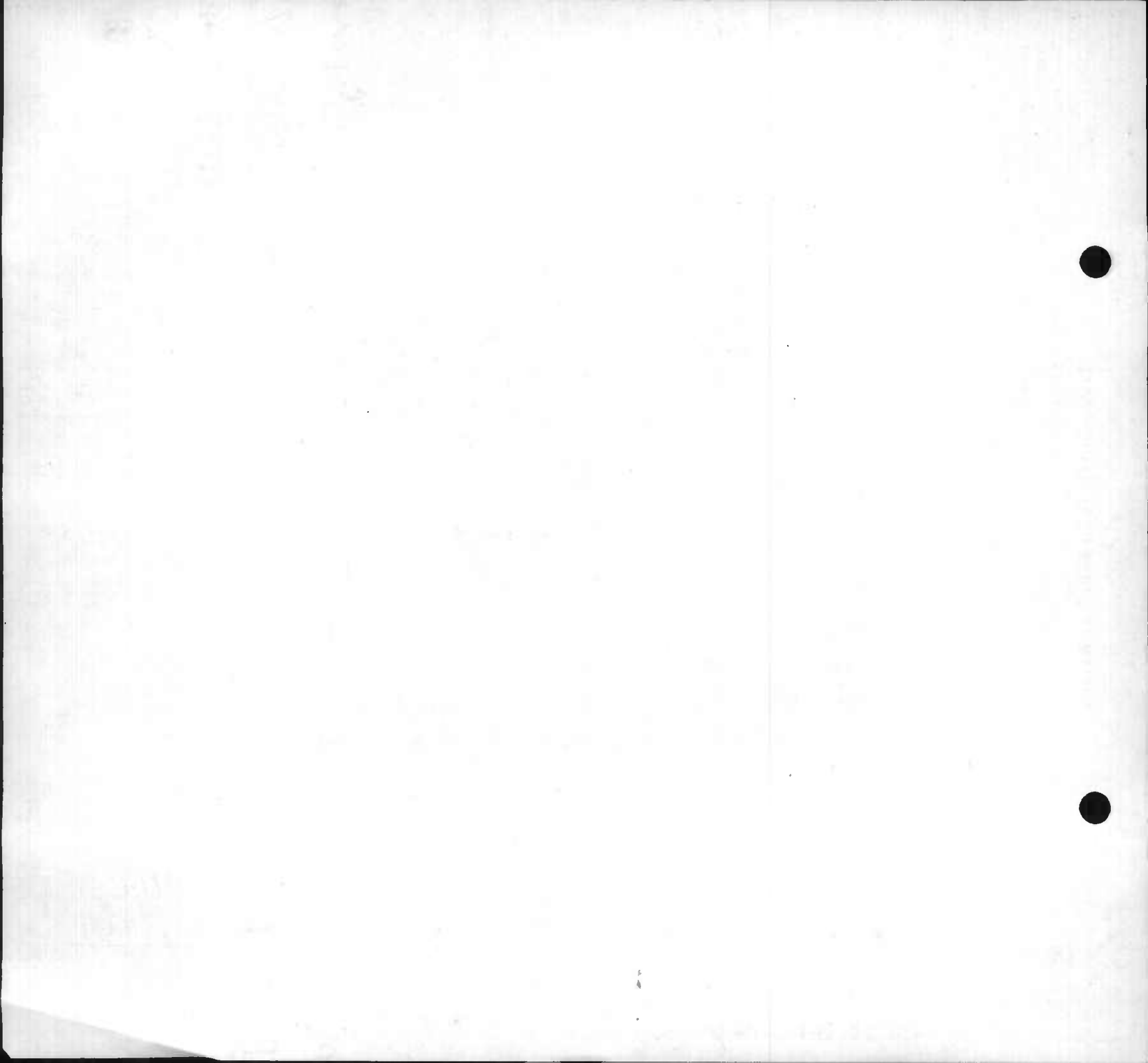
26. LANDS BELONGING TO THE COUNTY OF YAVAPAI

27. LANDS BELONGING TO THE COUNTY OF YAVAPAI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

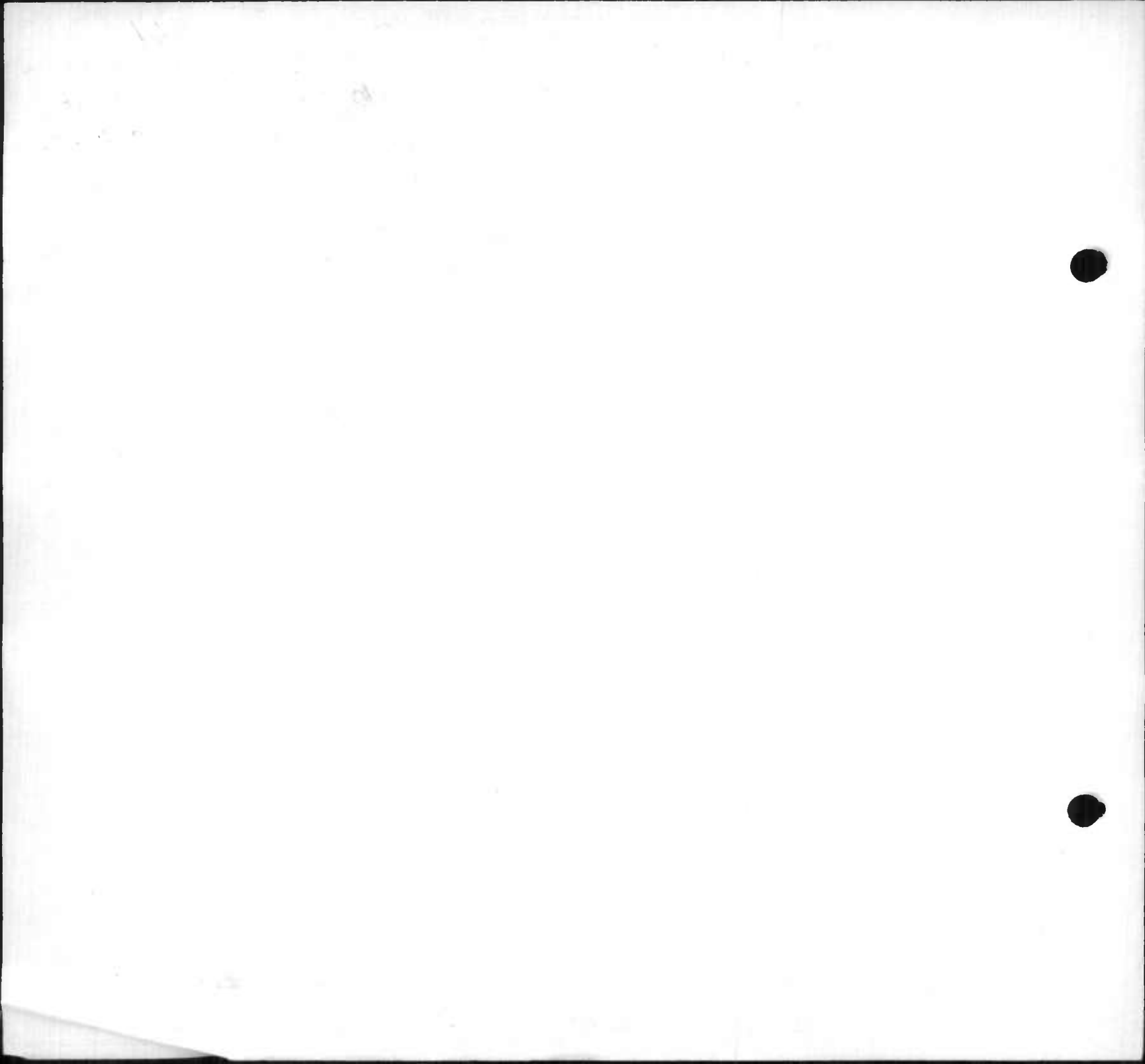
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
REG. NO. 71 8658										
BIRTH NO. <u>C-200 71 8658</u>										
1. NAME OF DECEASED (Type or Print) <u>EMMA COOK</u>					2. DATE AND HOUR OF DEATH <u>9-10-71</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>					A. STATE <u>MARYLAND</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY <u>604</u>					
					C. CITY OR TOWN <u>BALTIMORE</u>					
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
					E. STREET AND NUMBER <u>13 N. DURHAM ST</u>					
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1902</u>		9. AGE (In years lost birthday) <u>69</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Snow Hill Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>JOHN VICTOR</u>					14. MOTHER'S MAIDEN NAME <u>GRACE COLLINS</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-24-5766</u>		17. INFORMANT <u>LEROY EVANS 11 N. DURHAM ST</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>1977.01</u> Terminal metastatic CA to Lungs + Heart - 1° unknown					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u>					(B) <u>Plural effusion; pericardial effusion</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 month</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION <u>9/6</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>			20A. AUTOPSY? (Yes or No) <u>0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>No injury</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> 19 <u>71</u> to <u>9/4</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>did not</u> view the body after death.										
23A. SIGNATURE <u>M. Tucker M.D.</u>								23B. DATE SIGNED <u>9/14</u>		
23C. PHYSICIAN'S NAME (Type) <u>M. Tucker M.D.</u>								23D. ADDRESS <u>Box 83 Johns Hopkins Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>9-71</u>			24C. NAME OF CEMETERY or CREMATORY <u>Int'l Mt. Cal</u>			24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>			25C. FUNERAL DIRECTOR <u>Walter Wilson / 1000 Crantley</u>			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-650 8659				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 1061	
BIRTH NO. 21				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Parham Robert				2. DATE AND HOUR OF DEATH 9/10/53 am			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harbor Univ MCC - 1213 Light St.				A. STATE Harbor U. NCC - 1213 Light St			
5. SEX M				6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5/03/92		9. AGE (In years last birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Charles Parham				14. MOTHER'S MAIDEN NAME Rebecca Myrick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) m				16. SOCIAL SECURITY NO. 212-05-4528		17. INFORMANT Helen Howell ADDRESS Same	
18. 185X I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma - Prostate			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF: Metastasis			
ANTECEDENT CAUSES				(C) A.J.C. V. Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				?			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 71 to 9/10 19 71				that (I) (we) lost saw the deceased alive on 9/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph S. Blum				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/10/71	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD				23D. ADDRESS 1115 N Calvert St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-13-71		24C. NAME of CEMETERY or CREMATORY MT CALVARY		24D. LOCATION (City, town, or county) (State) ARUNDEL Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR John E. Taylor R.D.		25C. FUNERAL DIRECTOR E. Gray O. Wilson		ADDRESS	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-400 71		8660		71 8660	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Garnetta Hall		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 10, 1971		Hour 9:29 PM M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 10, 1971		Hour 9:29 PM M.	
6. SEX Female		7. RACE Colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept 12 1949		10. AGE (in years last birthday) 22		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Brines		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Esther Duggs		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Esther Duggs		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple stab wounds (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1805 Henneman Ave. 808	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Sept. 10, 1971 9:20 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? stabbed during argument with stepfather	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 11, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-71		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION (City, town, or county) (State) Baltimore County Md		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR R. E. Talbot, M.D.	
25C. FUNERAL DIRECTOR Baltimore 1011 Brantley		25D. ADDRESS			

11-00 11-00 11-00

8-250

W-300⁷¹

8661

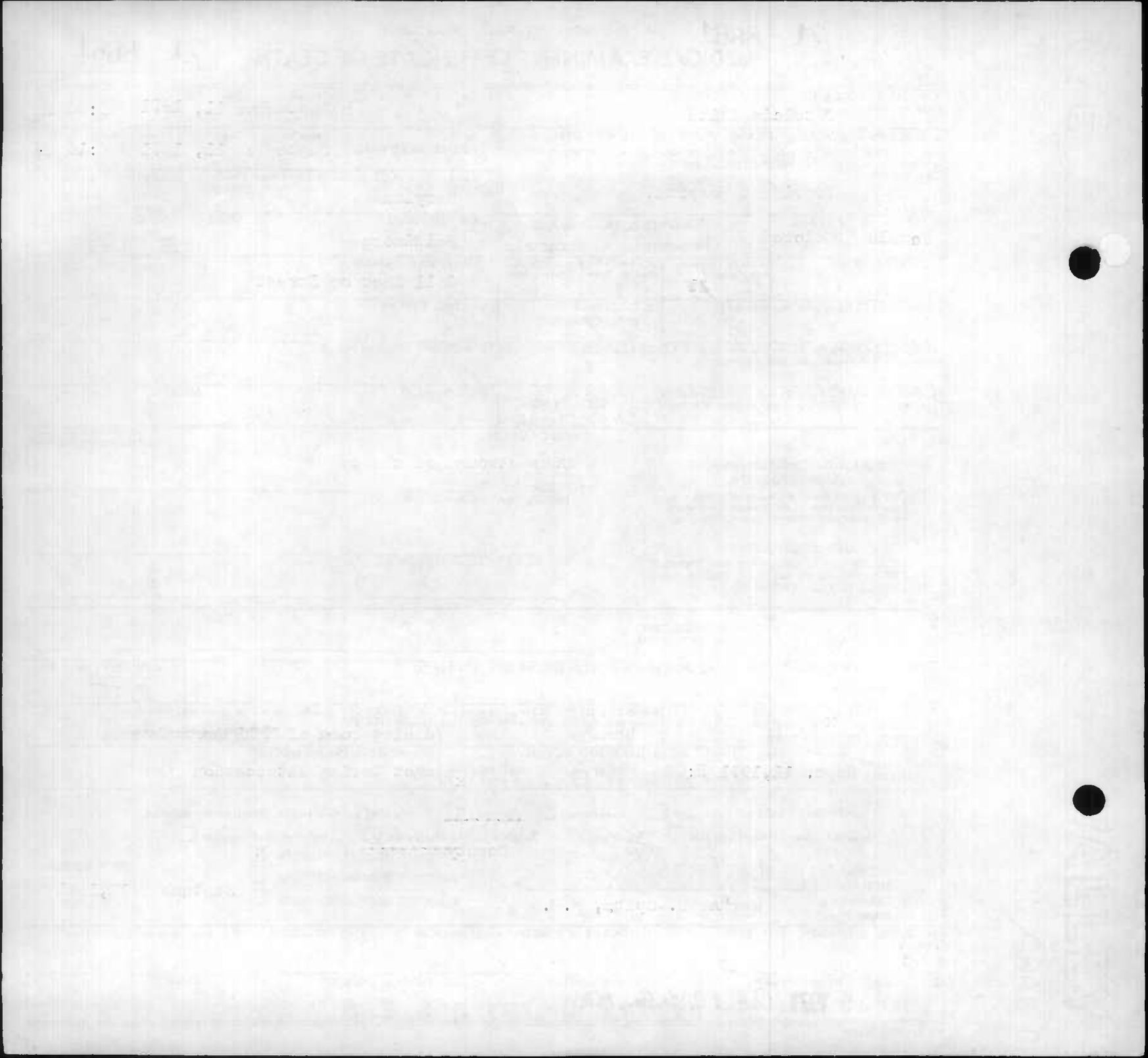
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8661
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Patricia White				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 11, 1971 Hour 5:00 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital				3. DATE PRONOUNCED DEAD Month Day Year September 11, 1971 Hour 6:15 PM	
6. SEX Female		7. RACE Colored		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 28-1952		10. AGE (In years last birthday) 19		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Shumard Monford		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
15. MOTHER'S MAIDEN NAME Mary E. Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-58-7372	
18. INFORMANT Shumard Monford		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshotwound of chest ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION Sept 11, 1971		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? dining room of 1328 North Avenue	
22D. TIME OF INJURY (APPROX.) Sept. 11, 1971 5:00 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71		24C. NAME OF CEMETERY or CREMATORY Baltimore Cat	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		24F. DATE REC'D BY HEALTH DEPT. SEP 15 1971	
24G. NAME OF REGISTRAR Robert E. Taylor, M.D.		24H. FUNERAL DIRECTOR 1001 Crumby Rd		24I. ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mary Munford		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> September 11, 1971		Hour 5:00 PM
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 11, 1971		Hour 6:15 PM
6. SEX Female		7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (in years lost birthday) 52	11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Gunshotwound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) between kitchen & dining room, 1328 W. North Ave.
22D. TIME OF INJURY (APPROX.) Sept. 11, 1971 5:00 PM		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during argument
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED September 12, 1971				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-15-71		24C. NAME OF CEMETERY or CREMATORY Northwood Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		
25B. NAME OF REGISTRAR R. C. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS H. B. Wilson		

UNITED STATES DEPARTMENT OF AGRICULTURE

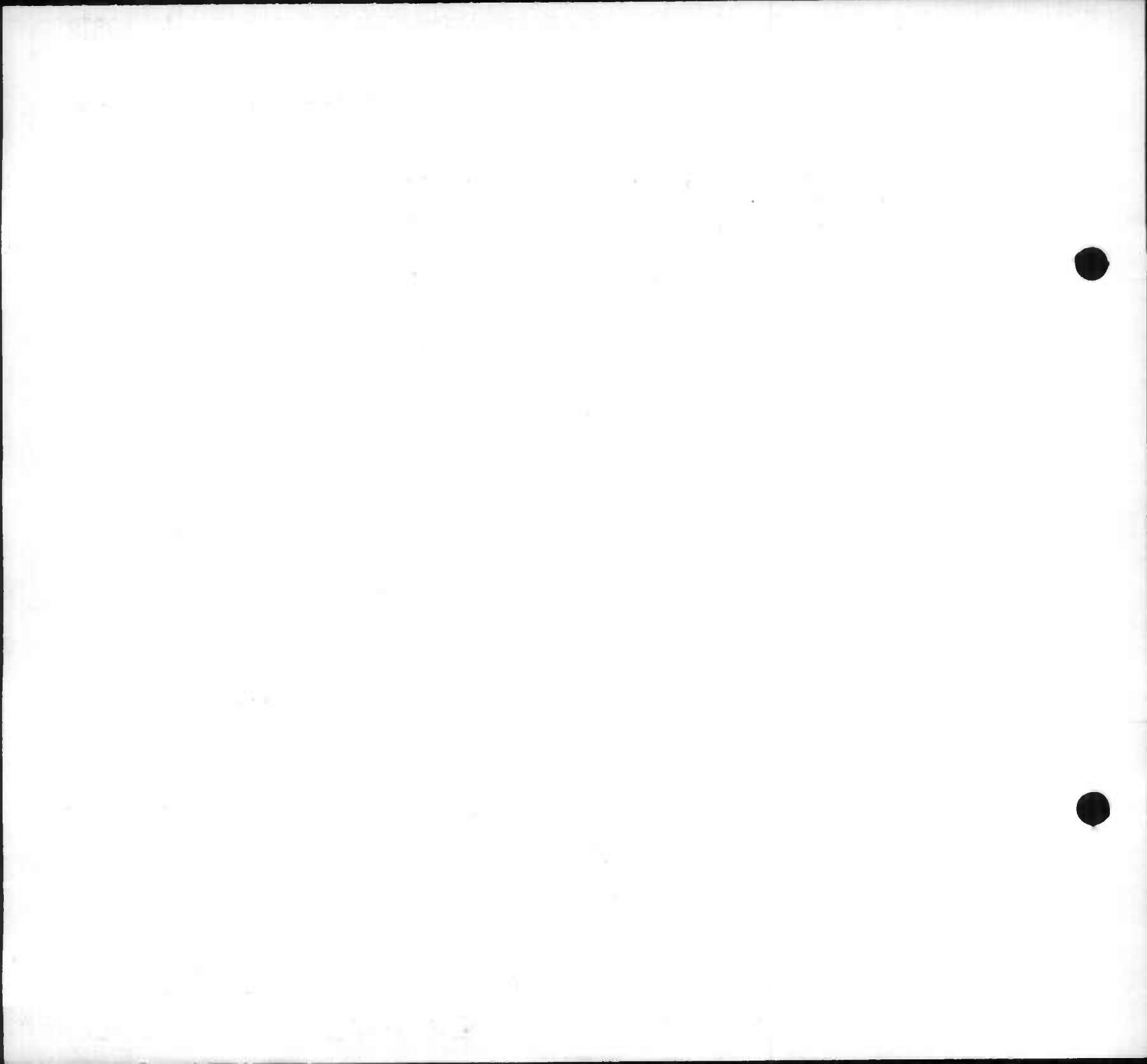
WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing botanical or agricultural findings.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-36571 8663		CERTIFICATE OF DEATH		71 8663	
1. NAME OF DECEASED (Type or Print) Christine WATERS			2. DATE AND HOUR OF DEATH September 8, 1971 1:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2007 Sinclair Lane		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/95	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 160-26-0647		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiorespiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Heart Failure (B) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis CUM (C) Gen & Congenital Defects			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 6, 1969 to September 8, 1971 that (I) (we) last saw the deceased alive on Sept 8, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William D Appleford			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9-11-71		24C. NAME of CEMETERY or CREMATORY Mt CALVARY
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971			25B. NAME OF REGISTRAR E. O. Wilson		25C. FUNERAL DIRECTOR ADDRESS 1000 BRANTICE AVE



1

W-30071

8664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8664

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) Julia White2. DATE OF DEATH
Known ☐ Month Day Year
Estimated ☒ September 12, 1971 Hour 12:20 AM4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION
3514 Holmes Avenue 9-16-713. DATE PRONOUNCED DEAD
Month Day Year Hour
September 12, 1971 12:40 AM5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)
A. STATE Maryland B. COUNTY 1304

6. SEX Female

7. RACE Colored

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?
YES ☒ NO ☐

9. DATE OF BIRTH Aug 9 1923

10. AGE (In years lost birthday) 47

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 3514 Holmes Avenue

11. BIRTHPLACE (State or foreign country) North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lomue Mitchell

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Bathe Royal

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No

17. SOCIAL SECURITY NO.

18. INFORMANT Nelson White Lewis ADDRESS

19. 30371

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic-cardiovascular-disease

(A) IMMEDIATE CAUSE Acute alcoholic intoxication
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 21

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED September 12, 1971

24A. BURIAL CREMATION, REMOVAL (Specify) Buried

24B. DATE 9-17-71

24C. NAME of CEMETERY or CREMATORY Whites Cat

24D. LOCATION (City, town, or county) (State) Whites Md

25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971

25B. NAME OF REGISTRAR Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Letter from M.E.'s office

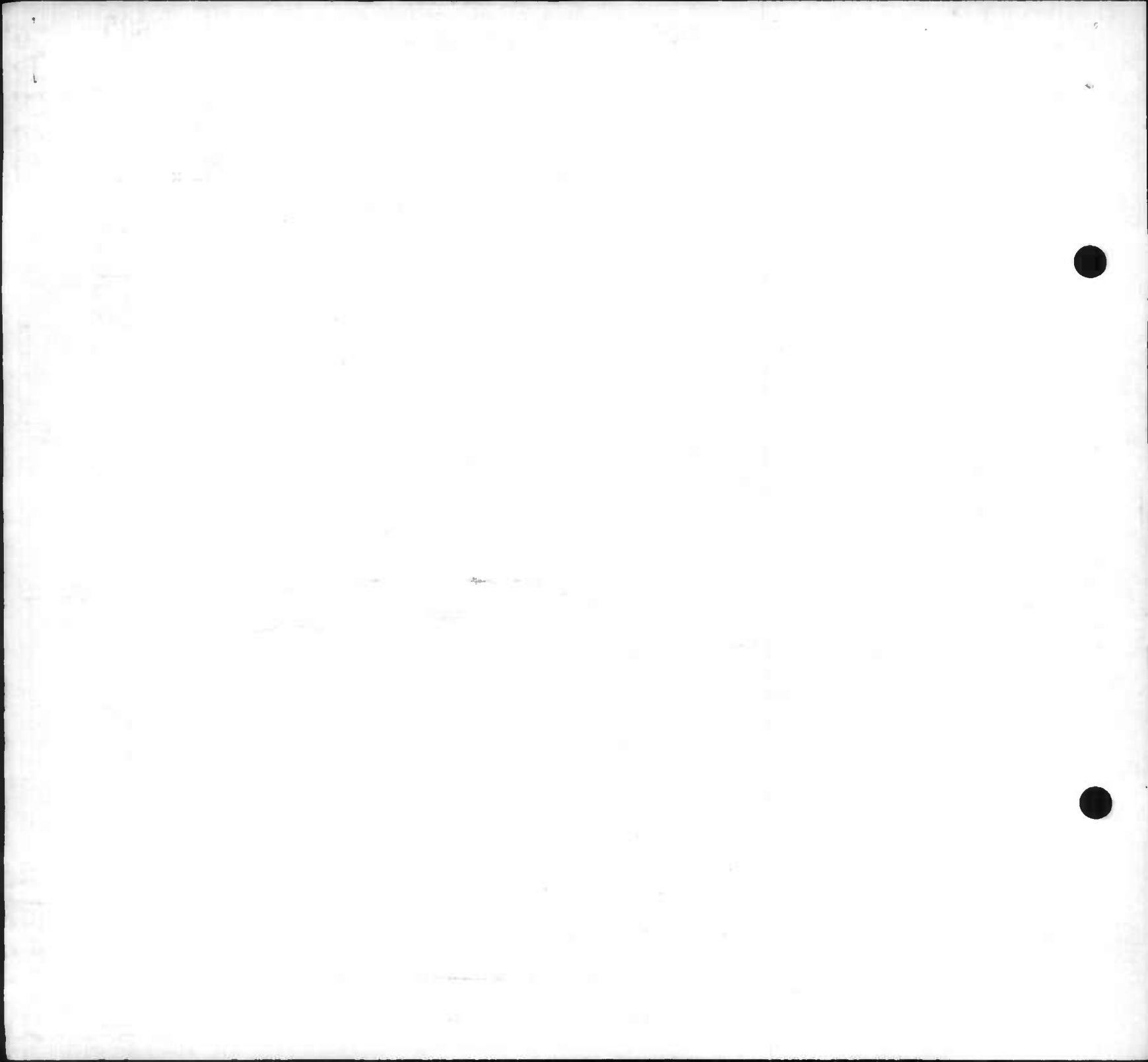
9-16-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

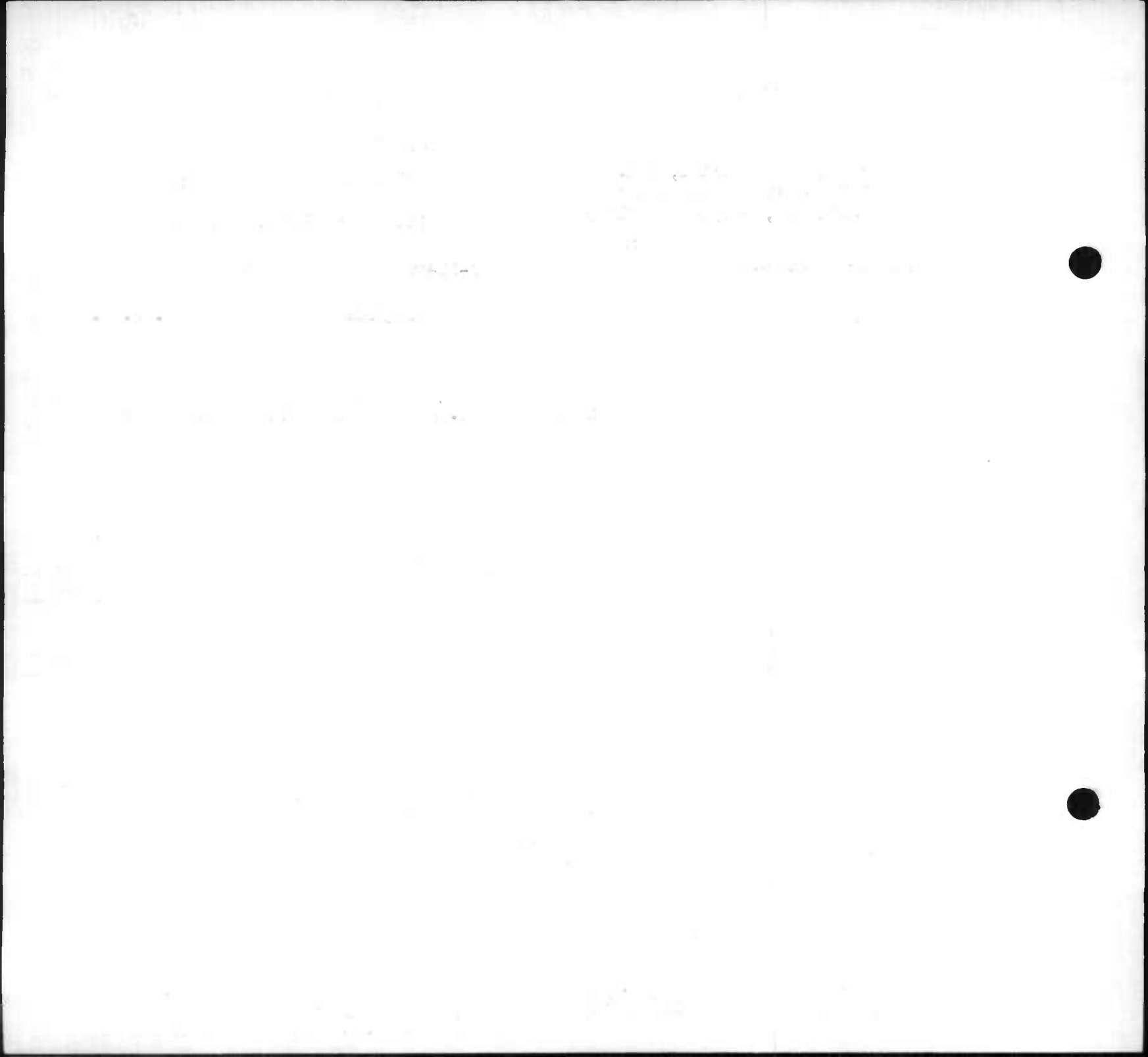
BALTIMORE CITY HEALTH DEPARTMENT				71 8665		REG. NO. 71 8665	
A-536		71 8665		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Charles Anderson</u>				2. DATE AND HOUR OF DEATH <u>9/13/71</u> <u>12:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hosp</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u>		B. COUNTY <u>21231 381</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>208 HERRING CT</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-04</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ANDERSON</u>				14. MOTHER'S MAIDEN NAME <u>KATIE Morgan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 09 0707</u>		17. INFORMANT <u>Essie Anderson 2534 Judson St</u>			
18. <u>410.91</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Ventricular Fibrillation</u> <u>30 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Acute Myocardial Infarction</u>		<u>8 hrs</u>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> <u>1971</u> to <u>9/13</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>9/13</u> <u>1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Keith L. Klein M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/13/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>KEITH L. KLEIN M.D.</u> <u>Keith L. Klein, M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hosp BALT, MD</u>			
24A. BURIAL CREMATION, REMOVAL, (Specify) <u>Burial</u>		24B. DATE <u>9-18-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Chesapeake</u> <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, MD</u>		25C. FUNERAL DIRECTOR <u>Edwin 1000 Cranbury St</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

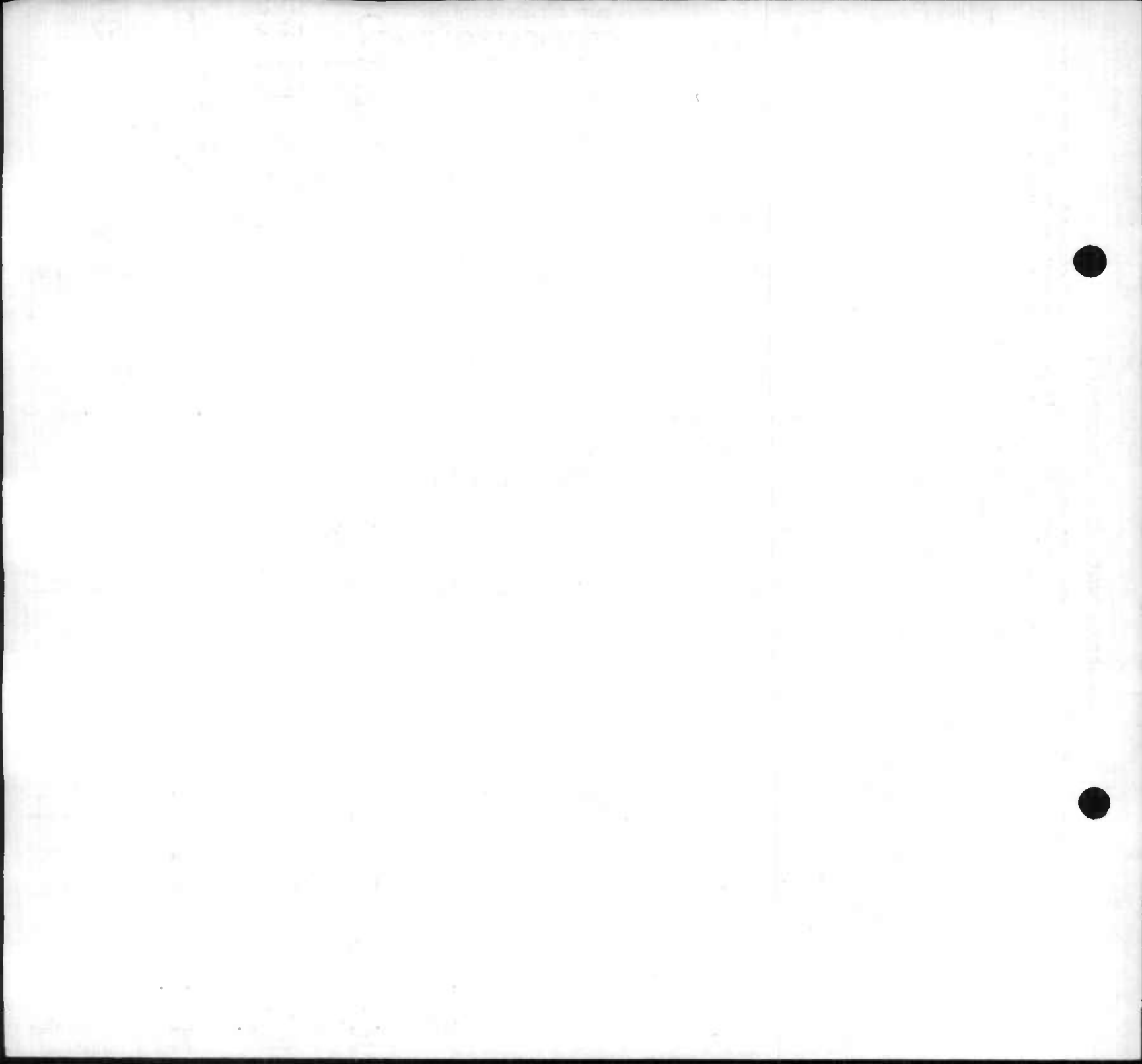
BALTIMORE CITY HEALTH DEPARTMENT				71 8666	
7-63071 8666				REG. NO.	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary Ford			2. DATE AND HOUR OF DEATH 9-10-71 11:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1501 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2116 Pennsylvania Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-98	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-14-3669	17. INFORMANT Mrs. Oneida Pinkney 2500 Terra Firma Mr. Joseph Ford (Husband) Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PROBABLE ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: Severe Malnutrition & dehydration DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days unknown unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-3 19 71 to 9-10 19 71 that (I) (we) last saw the deceased alive on 9-10 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Aurora C. Tan, M.D.				23B. DATE SIGNED 9-10-71	
23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D.				23D. ADDRESS PROVIDENT HOSPITAL, BALTIMORE, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-13-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR John E. Bailey, R.D.		25C. FUNERAL DIRECTOR V. Bailey	
25D. ADDRESS Kelson F.H. 1348 Calhoun Street					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

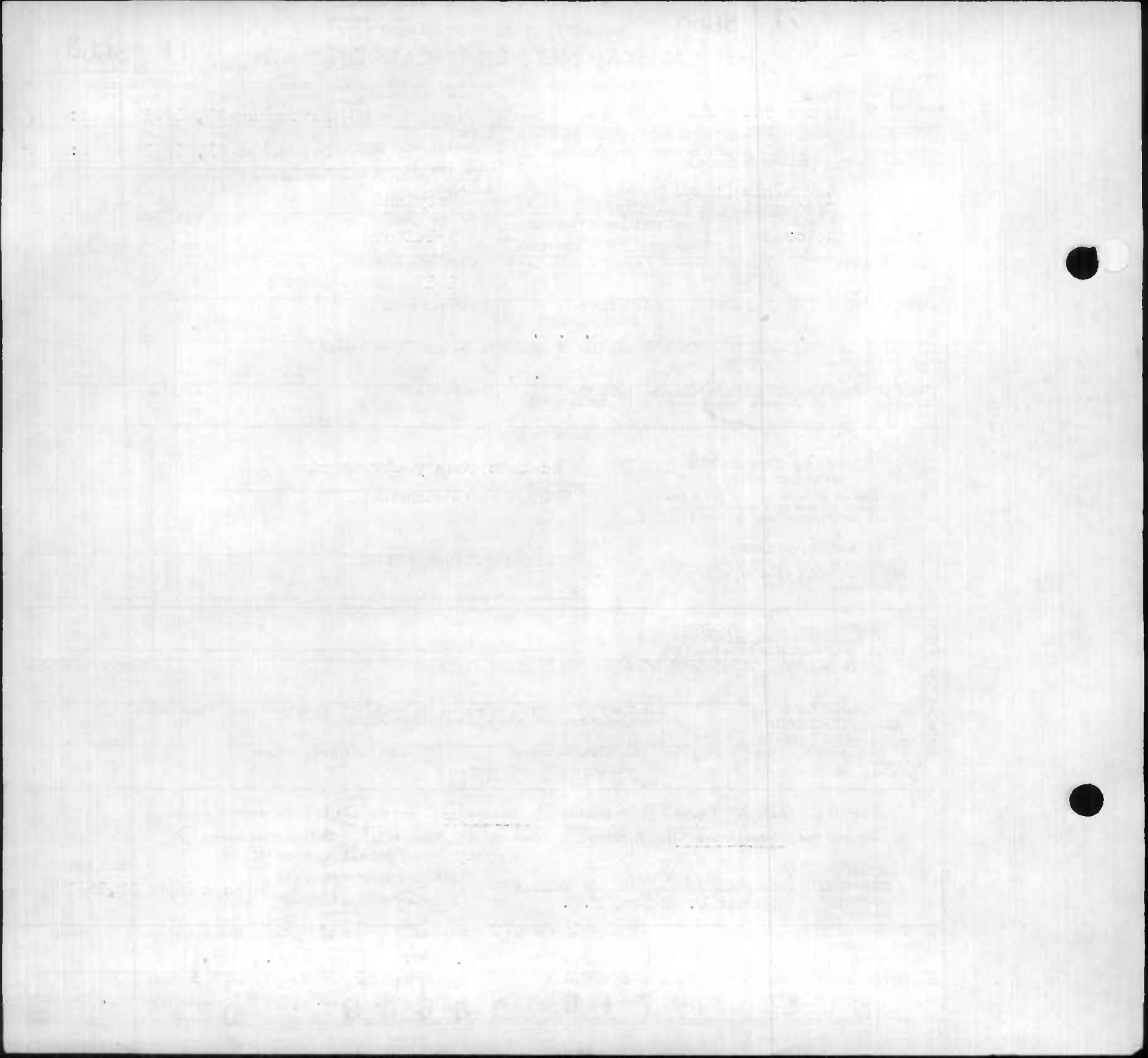
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8667</u>	
BIRTH NO. <u>0-34071 8667</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>OUTLAW, AVON</u>			2. DATE AND HOUR OF DEATH <u>SEPTEMBER 13 1971 00:10 a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNION MEMORIAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>908</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u>			6. RACE <u>N.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>01/16/1939</u>			9. AGE (In years last birthday) <u>32</u>		10. Under 1 Yr. Months Days <u>8</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ROY</u>		
14. MOTHER'S MAIDEN NAME <u>WILLARD BRADBERRY</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Williard Phillips 101 E. 20th St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>INTERNAL HEMORRHOGE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>COAGULOPATHY</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CIRRHOSIS + ALCOHOLIC HEPATITIS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 29 1971</u> to <u>SEPTEMBER 13 1971</u> that (I) (we) last saw the deceased alive on <u>SEPT. 13 1971</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar Villard</u>				23B. DATE SIGNED <u>SEPT. 13/1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR VILLARD</u>				23D. ADDRESS <u>33 rd and Calvert St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-16-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hook's Grove Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, N.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>			
25B. NAME OF REGISTRAR <u>V. Bailey</u>		25C. FUNERAL DIRECTOR <u>1348 N. Calhoun Street</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

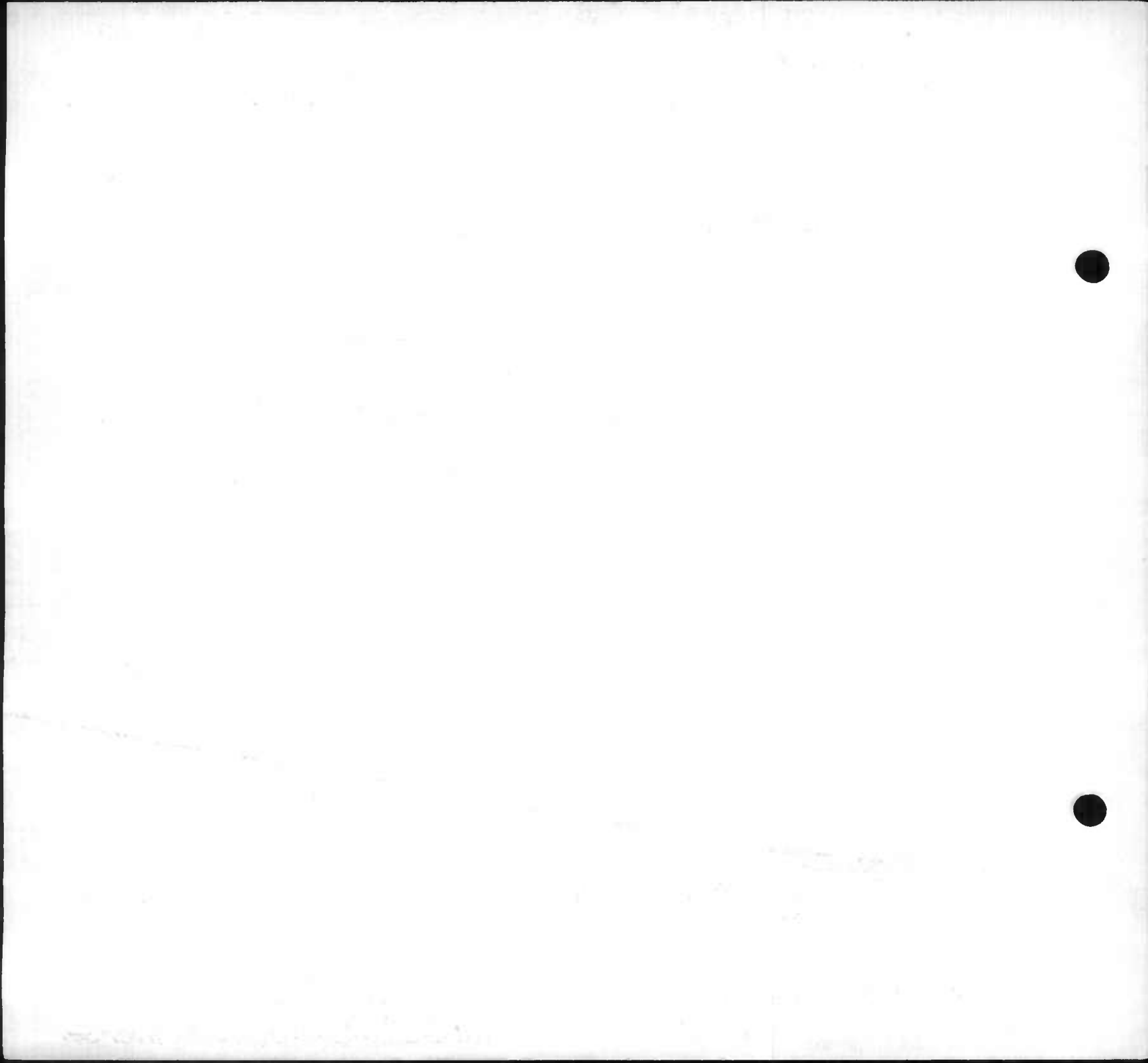
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Evans Peterkin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> September 11, 1971		Hour 5:00 PM
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Levindale Nursing Home Greenspring & Belvedere		3. DATE PRONOUNCED DEAD Month Day Year September 11, 1971		Hour 5:00 PM
6. SEX Male		7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2-12-43		10. AGE (In years lost birthday) 28	11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mack Boston		14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
15. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1603		16. STREET AND NUMBER 1615 Riggs Avenue		
17. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) orderly		18. KIND OF BUSINESS OR INDUSTRY Levindale N.H.		19. MOTHER'S MAIDEN NAME Beatrice Peterkin
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		21. SOCIAL SECURITY NO.		22. INFORMANT Beatrice Peterkin
23. ADDRESS same		24. CAUSE OF DEATH		
19. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (C) DUE TO, OR AS A CONSEQUENCE OF:				
25. DATE OF OPERATION 2		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) yes
28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
31. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 12, 1971 ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				
34. BURIAL CREMATION, REMOVAL (Specify) Burial		35. DATE 9-16-71		36. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.
37. LOCATION (City, town, or county) Balto., Md.		38. STATE (State)		
39. DATE REC'D BY HEALTH DEPT. SEP 15 1971		40. NAME OF REGISTRAR Robert J. [illegible]		41. FUNERAL DIRECTOR V. Bailey
42. ADDRESS Kelson F.H. 1348 Calhoun St.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

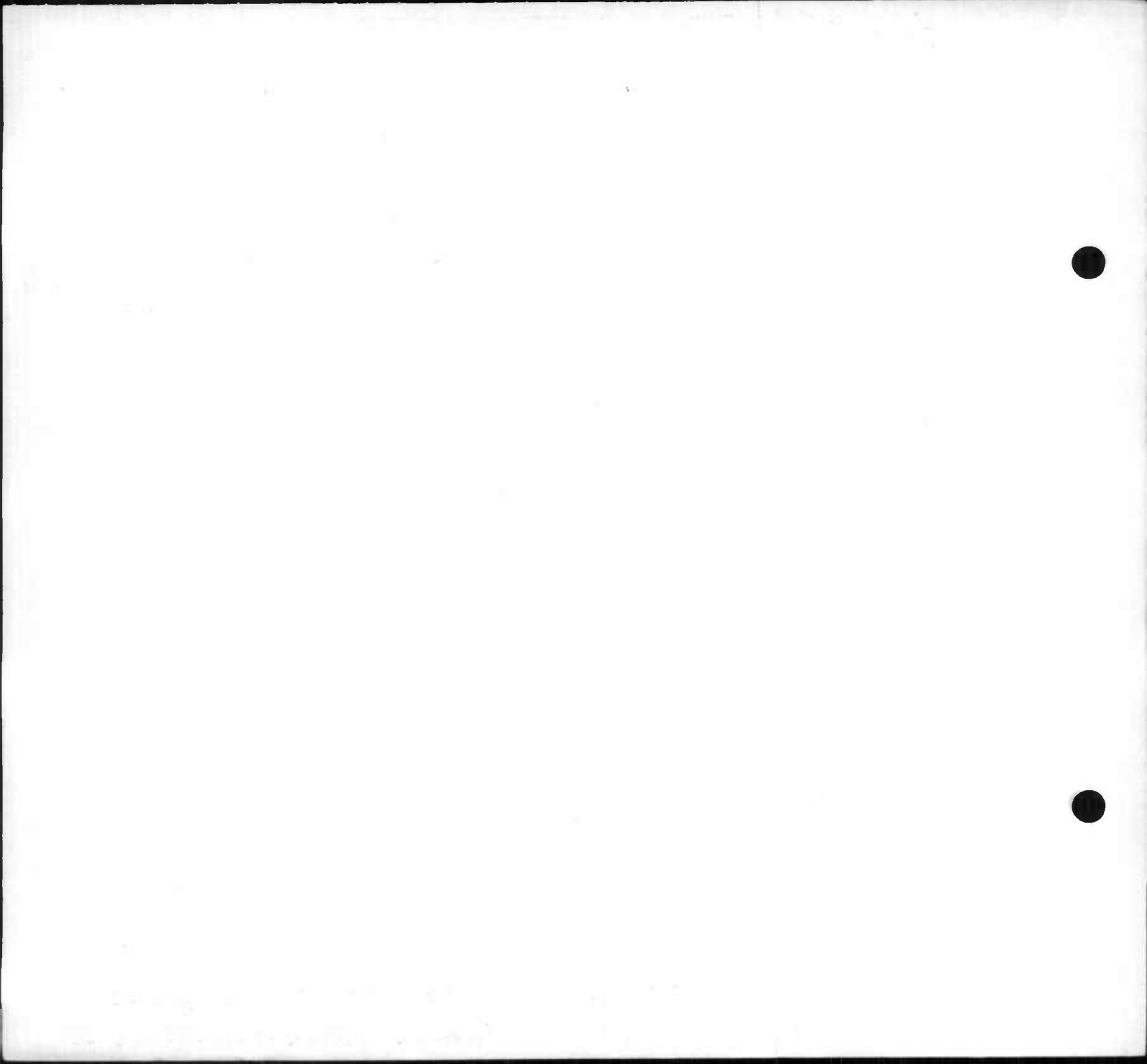
<p>BIRTH NO. <u>J-635 71 8669</u></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>71 8669</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Lillian Jordan</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9-11-71</u> <u>12 55 P</u> M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2631 E. Chase St</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT. CITY</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2631 Chase St</u></p>	
<p>5. SEX <u>F</u></p>	<p>6. RACE <u>Colebreed</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>3/3/81</u></p>
<p>9. AGE (In years last birthday) <u>90</u></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Dinwiddie County</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>	
<p>13. FATHER'S NAME <u>George Johnson</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Sally Johnson</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>	<p>17. INFORMANT <u>Mrs. Helen Stewart</u> <u>EMMETT JORDAN</u></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>150X I Carcinoma - Esophagus</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>8 mos</u></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION <u>D</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <u>August 6</u> 19 <u>71</u> to <u>August 14</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>August 20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>James F. Martin M.D.</u></p>		<p>23B. DATE SIGNED <u>9-11-71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>JAMES F. MARTIN</u></p>		<p>23D. ADDRESS <u>JOHN'S HOPKINS HOSPITAL</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u></p>		<p>24B. DATE <u>9-15-71</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Shiloh Baptist Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Dinwiddie Co., Va.</u></p>	
<p>25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 15 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Johnson</u></p>	
<p>25C. FUNERAL DIRECTOR <u>2431 E. Oliver St.</u></p>		<p>25D. ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

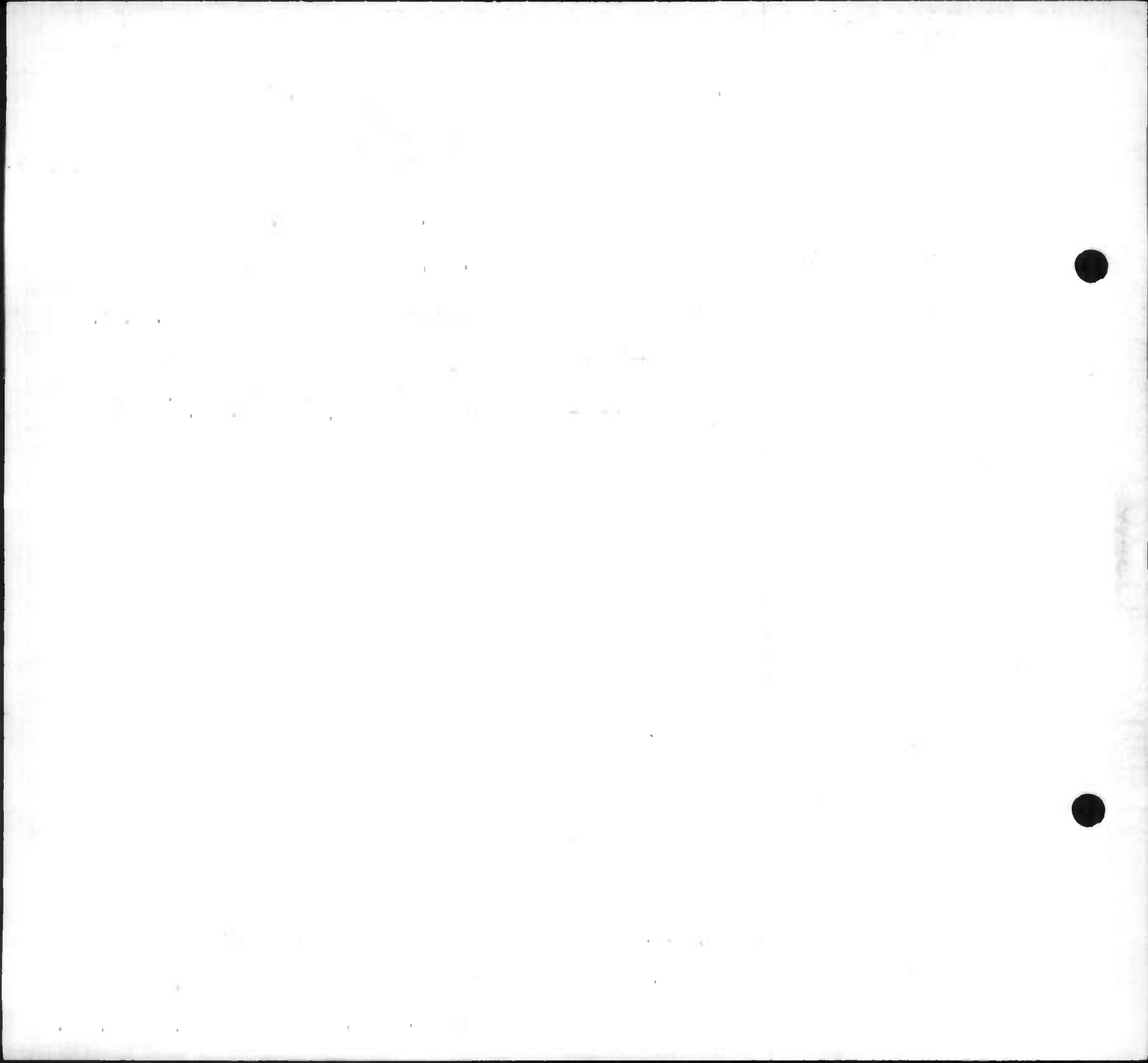
<p>BIRTH NO. H-165 71 8670</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8670</p>	
<p>1. NAME OF DECEASED (Type or Print) Hebron, Mary Helen</p>		<p>2. DATE AND HOUR OF DEATH Sept. 12, 1971 6:15 A.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 833</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1527 N. Milton Ave. 21213</p>	
<p>5. SEX F</p>	<p>6. RACE B</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11-20-07</p>
<p>9. AGE (In years last birthday) 63</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	<p>11. BIRTHPLACE (State or foreign country) Maryland</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME William Brown</p>	
<p>14. MOTHER'S MAIDEN NAME Fanny Thomas</p>		<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>	
<p>16. SOCIAL SECURITY NO. 212-28-3533</p>		<p>17. INFORMANT ADDRESS Hospital Chart</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.81</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of colon (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>19. DATE OF OPERATION 0</p>		<p>19A. CONDITION FOR WHICH OPERATION WAS PERFORMED NO</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>8-28-71</u> 19 to <u>9-12-71</u> 19 that (I) (we) last saw the deceased alive on <u>9-12-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Michael Colvin, M.D.</i></p>		<p>23B. DATE SIGNED 9-12-71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Michael Colvin, M.D.</p>		<p>23D. ADDRESS Good Samaritan Hospital</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 9-17-71</p>	
<p>24C. NAME OF CEMETERY or CREMATORY ARBUTHUS MEMORIAL PARK ARBUTHUS, MARYLAND</p>		<p>24D. LOCATION (City, town, or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Jaber, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Randolph J. Collick</p>		<p>25D. ADDRESS 2431 E. Oliver St.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

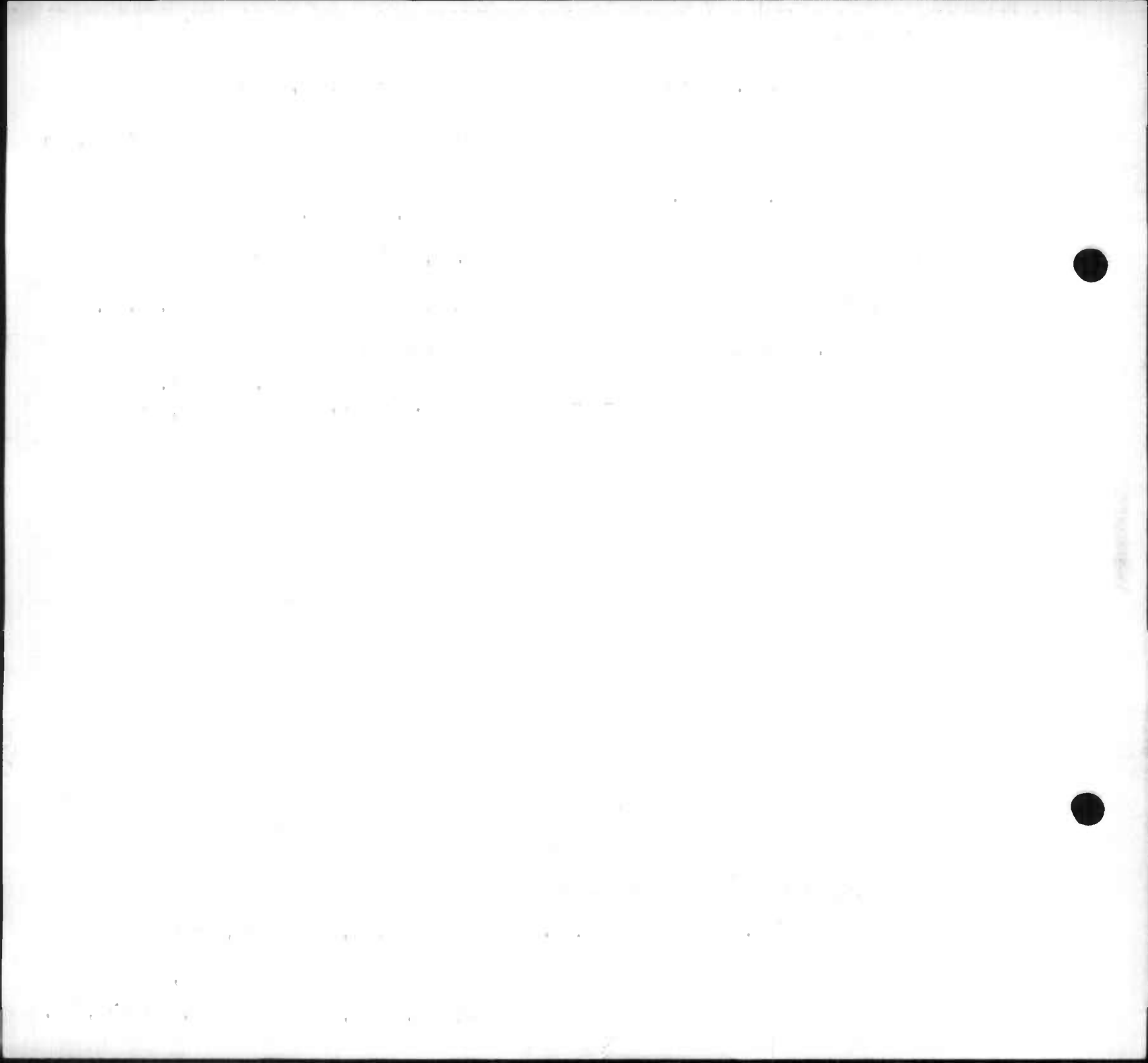
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8671	
BIRTH NO. 6-630 71 8671					
1. NAME OF DECEASED (Type or Print) Raymond J. Garrity			2. DATE AND HOUR OF DEATH August 25, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 103		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 729 S. Lakewood Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1889	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paymaster		10B. KIND OF BUSINESS OR INDUSTRY City Hall		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Garrity			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-3039		17. INFORMANT (Daughter) 1541 Burnwood Rd. Balto. Md. 21239	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 + 150X CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cadaveric Anoxia (B) DUE TO, OR AS A CONSEQUENCE OF: ASCD (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ca of esophagus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that N (this hospital) attended the deceased from 8/25 19 71 to Aug 25 19 71 that N (we) last saw the deceased alive on Aug 25 19 71 and that N (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon Landau, M.D.			23B. DATE SIGNED 8-25-71		
23C. PHYSICIAN'S NAME (Type) Leon Landau, M.D.			23D. ADDRESS Baltimore City Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/71		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 2829 Hudson St. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">G-620</div> <div style="font-size: 2em; font-weight: bold;">71</div> <div style="font-size: 2em; font-weight: bold;">8672</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO.</div> <div style="font-size: 2em; font-weight: bold;">71</div> <div style="font-size: 2em; font-weight: bold;">8672</div>	
<div style="font-weight: bold;">BIRTH NO.</div> <div style="font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-size: 0.8em;">(Type or Print)</div> <div style="font-size: 1.2em;">Elsie L. Garcia</div>		<div style="font-weight: bold;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 1.2em;">August 26, 1971</div>			
<div style="font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div> <div style="font-size: 0.8em;">FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div> <div style="font-size: 1.5em; margin-left: 20px;">00</div> <div style="font-size: 1.2em;">2203 St. Paul St.</div>		<div style="font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div style="font-size: 0.8em;">A. STATE B. COUNTY</div> <div style="font-size: 1.2em;">Maryland</div> <div style="font-size: 2em; font-weight: bold; margin-left: 20px;">1204</div> <div style="font-weight: bold;">C. CITY OR TOWN</div> <div style="font-size: 1.2em;">Baltimore</div> <div style="font-weight: bold;">D. INSIDE CITY LIMITS?</div> <div style="font-size: 0.8em;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div style="font-weight: bold;">E. STREET AND NUMBER</div> <div style="font-size: 1.2em;">2203 St. Paul St.</div>			
<div style="font-weight: bold;">5. SEX</div> <div style="font-size: 1.2em;">Female</div>	<div style="font-weight: bold;">6. RACE</div> <div style="font-size: 1.2em;">White</div>	<div style="font-weight: bold;">7. MARRIED</div> <div style="font-size: 0.8em;">NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>	<div style="font-weight: bold;">8. DATE OF BIRTH</div> <div style="font-size: 1.2em;">Nov. 1, 1892</div>	<div style="font-weight: bold;">9. AGE (In years last birthday)</div> <div style="font-size: 1.2em;">78</div>	<div style="font-size: 0.8em;">If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</div>
<div style="font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div style="font-size: 1.2em;">Housewife</div>		<div style="font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div>		<div style="font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-size: 1.2em;">Maryland</div>	<div style="font-weight: bold;">12. CITIZEN OF WHAT COUNTRY?</div> <div style="font-size: 1.2em;">U. S. A.</div>
<div style="font-weight: bold;">13. FATHER'S NAME</div> <div style="font-size: 1.2em;">James F. Edwards</div>		<div style="font-weight: bold;">14. MOTHER'S MAIDEN NAME</div> <div style="font-size: 1.2em;">Jenieve ?</div>			
<div style="font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-size: 1.2em;">No</div>		<div style="font-weight: bold;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 1.2em;">212-07-6022D</div>		<div style="font-weight: bold;">17. INFORMANT (Son) 2203 St. Paul St. ADDRESS</div> <div style="font-size: 1.2em;">Harry J. Garcia, Baltimore, Maryland</div>	
<div style="font-weight: bold;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-size: 1.2em;">412.31</div> <div style="font-weight: bold;">ANTECEDENT CAUSES</div> <div style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONOITION last.</div>		<div style="font-weight: bold;">CAUSE OF DEATH</div> <div style="font-size: 1.2em;">Arterio-sclerotic vas Hunt Dis.</div> <div style="font-weight: bold;">(A) IMMEDIATE CAUSE</div> <div style="font-size: 0.8em;">DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-weight: bold;">(B) DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-weight: bold;">(C) DUE TO, OR AS A CONSEQUENCE OF:</div>		<div style="font-weight: bold;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div style="font-size: 1.2em;">3 yrs</div>	
<div style="font-weight: bold;">II</div> <div style="font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div>					
<div style="font-weight: bold;">19A. DATE OF OPERATION</div> <div style="font-size: 1.2em;">2</div>		<div style="font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div style="font-weight: bold;">20A. AUTOPSY? (Yes or No)</div> <div style="font-size: 1.2em;">No</div>	
<div style="font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</div> <div style="font-size: 0.8em;">Inotify medical examined</div>		<div style="font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div style="font-weight: bold;">21C. WHERE DID INJURY OCCUR?</div> <div style="font-size: 0.8em;">(If in Baltimore City, give exact location)</div>	
<div style="font-weight: bold;">21D. TIME OF INJURY (APPROX)</div> <div style="font-size: 0.8em;">(Month) (Day) (Year) (Hour)</div>		<div style="font-weight: bold;">21E. INJURY OCCURRED</div> <div style="font-size: 0.8em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<div style="font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>	
<div style="font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from</div> <div style="font-size: 1.2em;">Jan. 5 1971</div> <div style="font-weight: bold;">19</div> <div style="font-size: 1.2em;">to Aug. 26</div> <div style="font-weight: bold;">1971</div> <div style="font-weight: bold;">that (I) (we) last saw the deceased alive on</div> <div style="font-size: 1.2em;">Aug. 23</div> <div style="font-weight: bold;">19 71</div> <div style="font-weight: bold;">and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div style="font-weight: bold;">23A. SIGNATURE</div> <div style="font-size: 1.5em;">Carl F. Benson</div>		<div style="font-weight: bold;">23B. DATE SIGNED</div>		<div style="font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em;">Carl F. Benson M. D.</div>	
<div style="font-weight: bold;">23D. ADDRESS</div> <div style="font-size: 1.2em;">5111 York Road, Baltimore, Maryland</div>		<div style="font-weight: bold;">23E. ADDRESS</div> <div style="font-size: 1.2em;">John U. Ouda, 7922 Wise Ave. Dundalk, Md.</div>			
<div style="font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 1.2em;">Burial</div>		<div style="font-weight: bold;">24B. DATE</div> <div style="font-size: 1.2em;">8/30/71</div>		<div style="font-weight: bold;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-size: 1.2em;">Western Cemetery</div>	
<div style="font-weight: bold;">24D. LOCATION (City, town, or county) (State)</div> <div style="font-size: 1.2em;">Baltimore, Maryland</div>		<div style="font-weight: bold;">25A. DATE REC'D BY HEALTH DEPT.</div> <div style="font-size: 1.2em;">SEP 15 1971</div>			
<div style="font-weight: bold;">25B. NAME OF REGISTRAR</div> <div style="font-size: 1.2em;">R. E. Kelly, Jr.</div>		<div style="font-weight: bold;">25C. FUNERAL DIRECTOR</div> <div style="font-size: 1.2em;">John U. Ouda, 7922 Wise Ave. Dundalk, Md.</div>			



1

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 8673

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROSALEE MITCHELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 9, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1971 8:45 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1538	
9. DATE OF BIRTH 7/27/1920		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Arelia Fernandez		18. INFORMANT ADDRESS Arelia McDonald, 3327 Forest Park Ave.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 9, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/14/71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR 471000 4870	
25C. FUNERAL DIRECTOR Kenneth Low		ADDRESS 4611 Park Heights Ave.	

(000)

X

X

17/17

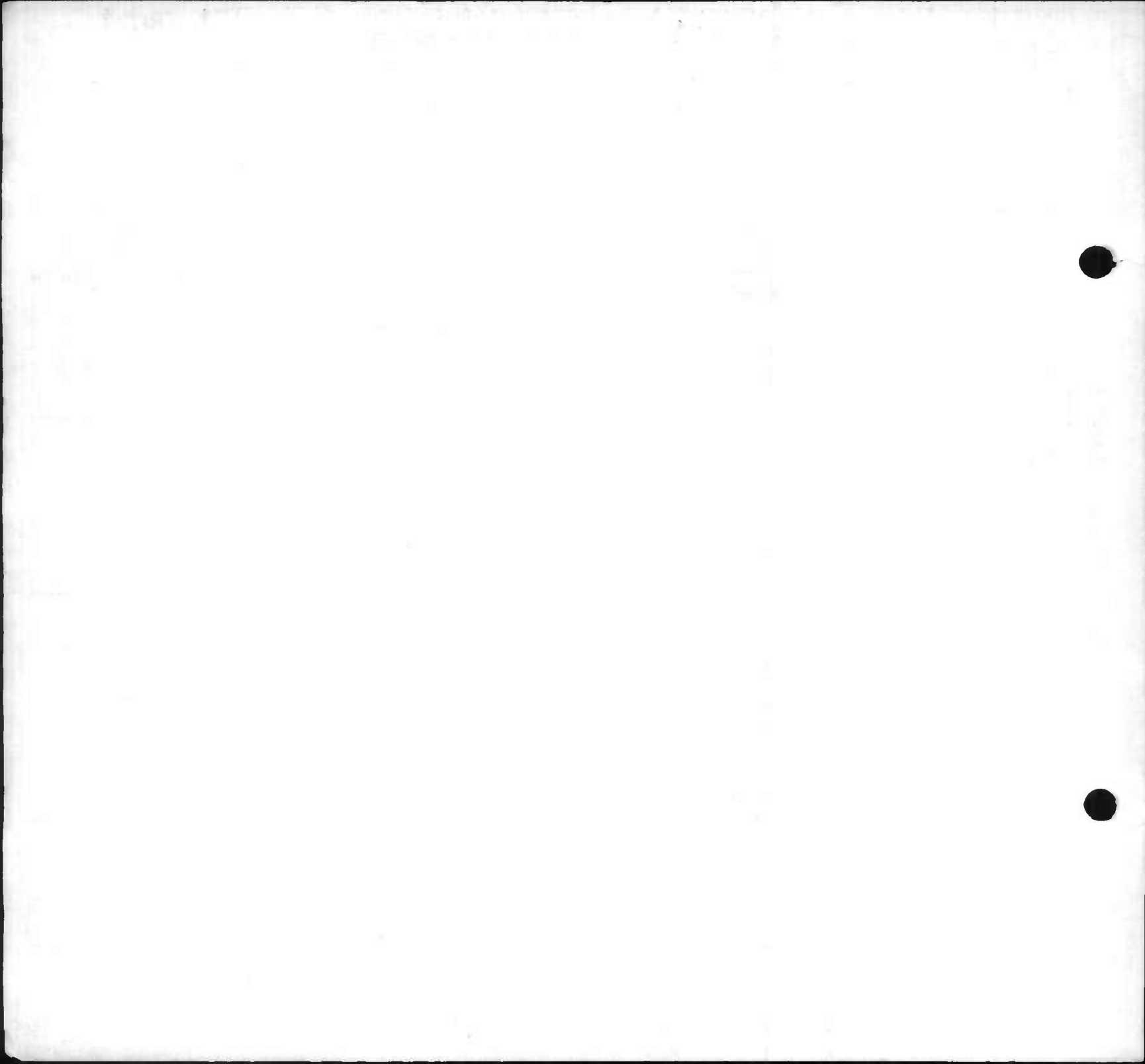
17/17

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

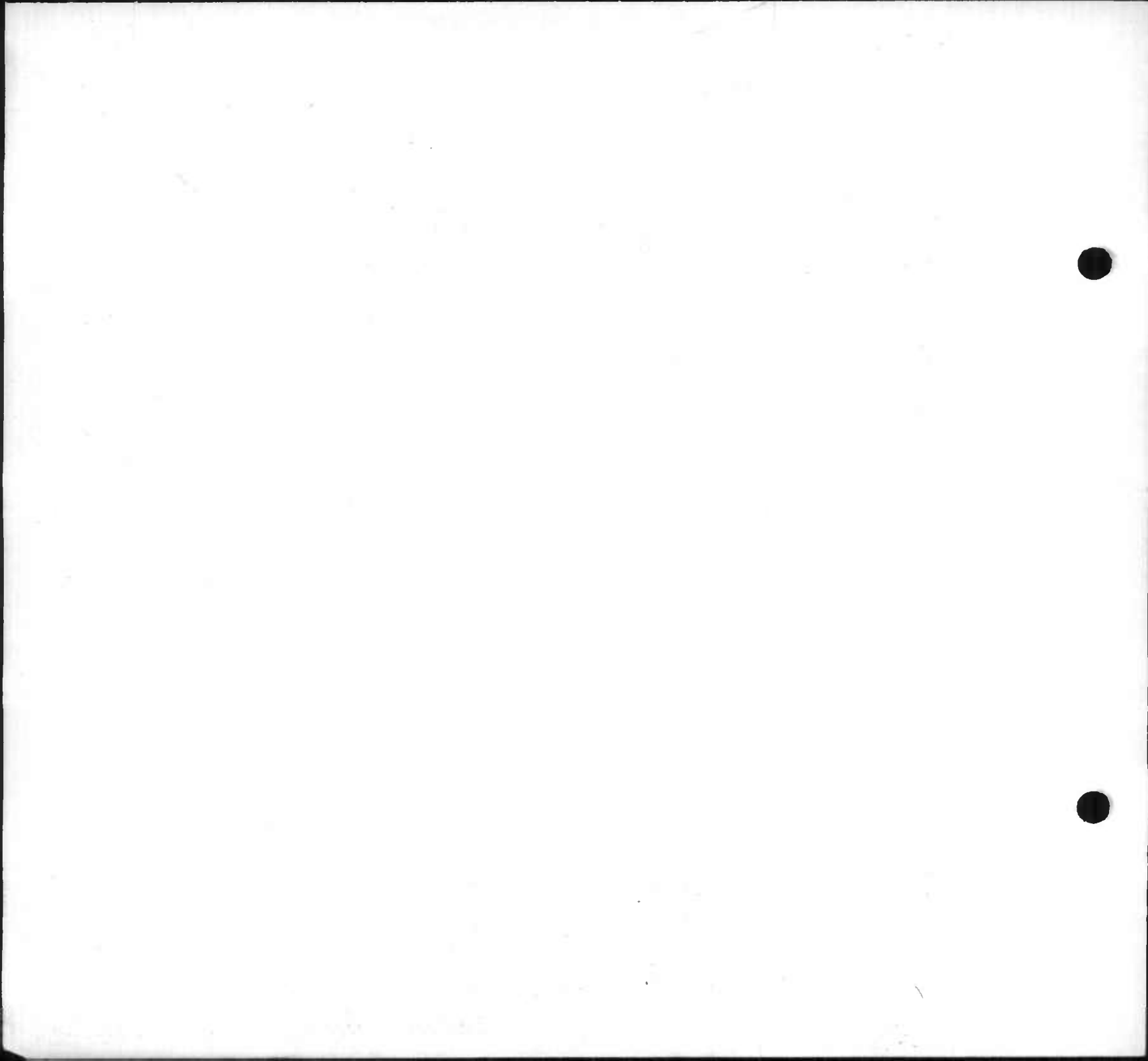
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8674	
S-36271 8674 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) SOPHIA M. STOWERS			2. DATE AND HOUR OF DEATH 3 PM 19-13-71 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL, BALTO - MD 21231			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2610		
5. SEX F		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-12-1919		9. AGE (In years last birthday) 52		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Package		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Richard M. Stowers			14. MOTHER'S MAIDEN NAME Helen Staworki (Shiels)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 09 5253		17. INFORMANT ADDRESS DR. SAULAM, CHURCH HOME & HOSPITAL, BALTO - MD 21231	
18. 150X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 28-10-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Oesophagus 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? — 22. I certify that (I) (this hospital) attended the deceased from 7-28-1971 to 9-13-1971 that (I) (we) last saw the deceased alive on 9-13-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE V. S. Saulam, M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED 9-13-71 23C. PHYSICIAN'S NAME (Type) DR. ANDERSON, M.D. 23D. ADDRESS CHURCH HOME & HOSPITAL, BALTO. MD 21231 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/17/71 24C. NAME OF CEMETERY OR CREMATORY Crest Lawn 24D. LOCATION (City, town, or county) (State) Balto. Md. 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971 25B. NAME OF REGISTRAR Robert E. Jaber, MD. 25C. FUNERAL DIRECTOR ADDRESS Joseph N. ZANNINO 263 S. CONKLING ST.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-510 71 8675		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8675	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hattie Cumbo</i>		2. DATE AND HOUR OF DEATH <i>9-13-71 12:25 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>805</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1645 Darley Ave.</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M.</i> 6. RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-6-12</i> 9. AGE (in years last birthday) <i>58</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Canner</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>S. Carolina</i>	
13. FATHER'S NAME <i>Henderson Turner</i>		14. MOTHER'S MAIDEN NAME <i>Cora ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>William Cumbo - 1645 Darley Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>170.71</i>		CAUSE OF DEATH <i>Lobar Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 Days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic Carcinoma</i>		<i>4 1/2 mo.</i>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of the Right Femur</i>		<i>9 mo.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1971</i> to <i>9-13-1971</i> that (I) (we) last saw the deceased alive on <i>9-4-1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene H. Owens MD</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>9-14-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eugene H. Owens MD</i>		23D. ADDRESS <i>1735 E. Federal St. Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burn</i>		24B. DATE <i>9-16-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 15 1971</i>		25B. NAME OF REGISTRAR <i>R. E. Tally, Jr.</i>	
25C. FUNERAL DIRECTOR <i>Edith Funeral Home - 1129 N. Center</i>		ADDRESS			

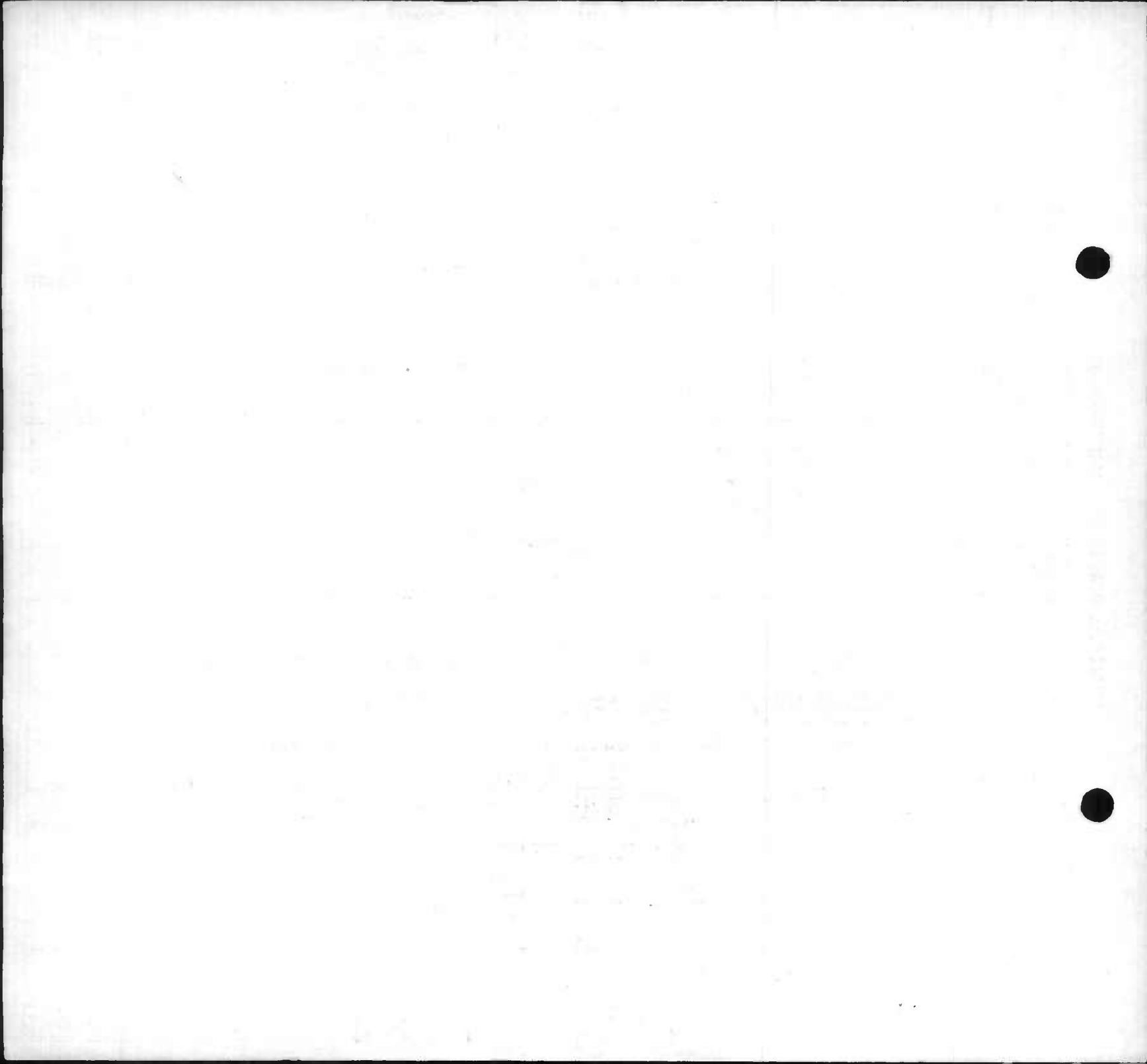


<p style="font-size: 24pt; margin: 0;">G-650</p> <p style="font-size: 18pt; margin: 0;">71 8576</p> <p style="font-size: 12pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 18pt; margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>71 8576</u></p>	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Andrew Green		Known <input checked="" type="checkbox"/> Month 9 Day 14 Year 71 Estimated <input type="checkbox"/> 9 14 71	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
2510 E. Hoffman Street		Month 9 Day 14 Year 71 Hour 9:05 A. M.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Male	7. RACE Negro	A. STATE Maryland B. COUNTY 833	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
2-25-25		2510 E. Hoffman Street	
10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
46		Crewe Va.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
George Hanks		Unemployed Laborer	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Irene Green		No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
		Irene Green 2510 E. Hoffman St.	
19. 571.8 1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
21. AUTOPSY? (Yes or No)		Partial autopsy	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		9-18-71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Arlington Memorial Park		Arlington, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
SEP 15 1971		Robert E. G. G. G.	
25C. FUNERAL DIRECTOR		ADDRESS	
Albert G. G. G.		11297 Calver St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

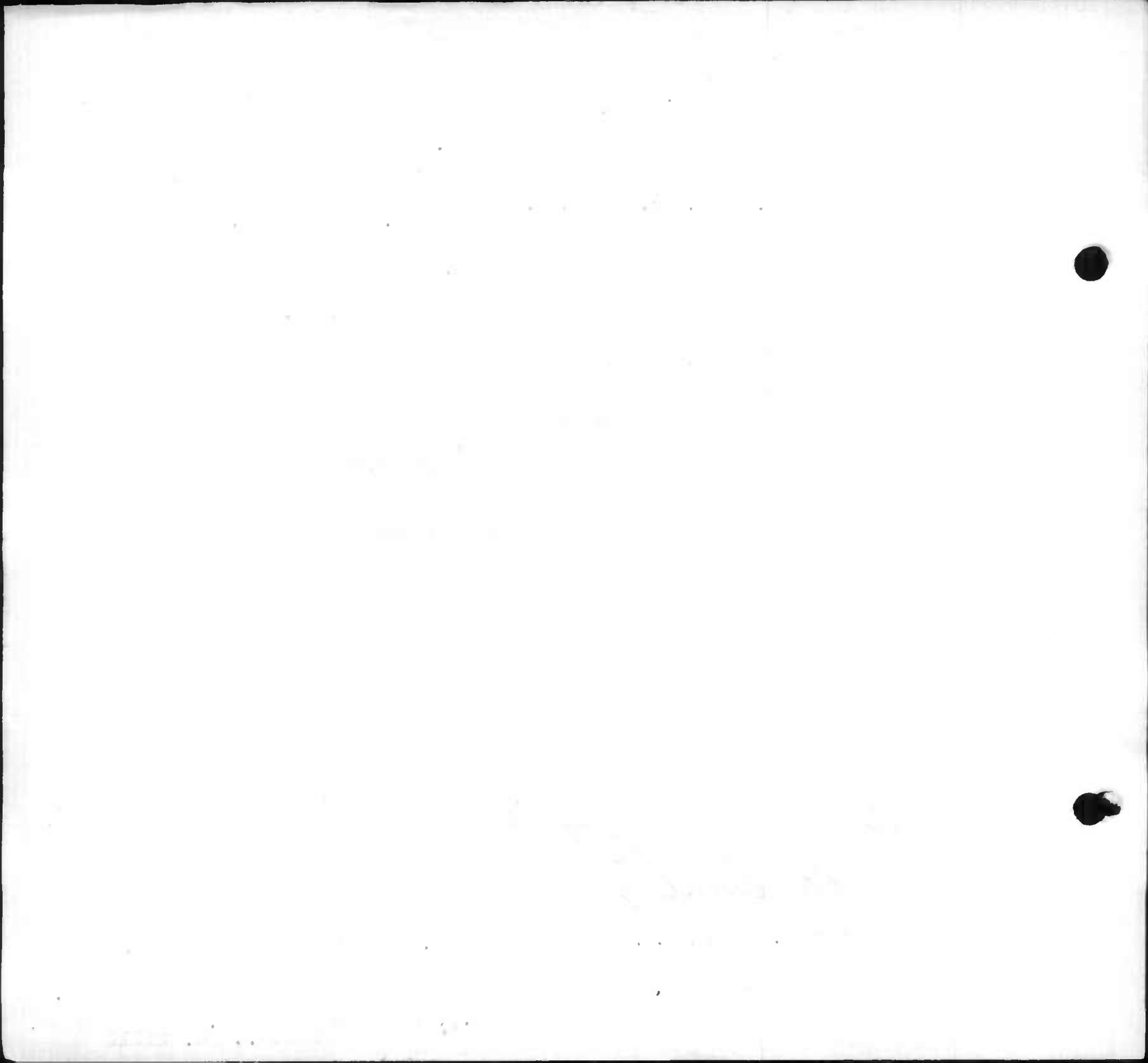
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8677</u>	
J-525 71 8677				CERTIFICATE OF DEATH	
BIRTH NO. <u>71 8677</u>		1. NAME OF DECEASED (Type or Print) <u>Johnson, Melvin</u>		2. DATE AND HOUR OF DEATH <u>9/13/71 10:20 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1002</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>725 Sterling St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-95</u>	9. AGE (In years last birthday) <u>75</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Lumber</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Fisher Laura ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Andrew Johnson - 18517 Cellington Ave</u> ADDRESS	
18. <u>412.2</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u> (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/13/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> 19 <u>71</u> to <u>9/13</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Tolhu OHE</u>		23B. DATE SIGNED <u>9/13/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Tolhu OHE MD</u>	
23D. ADDRESS <u>Mercy Hospital Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-18-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		24D. LOCATION (City, town, or county) <u>A. A. County Md.</u>		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. Taylor</u>		25C. FUNERAL DIRECTOR <u>Robert J. Taylor</u>	
25D. ADDRESS <u>11297 Cawthra St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

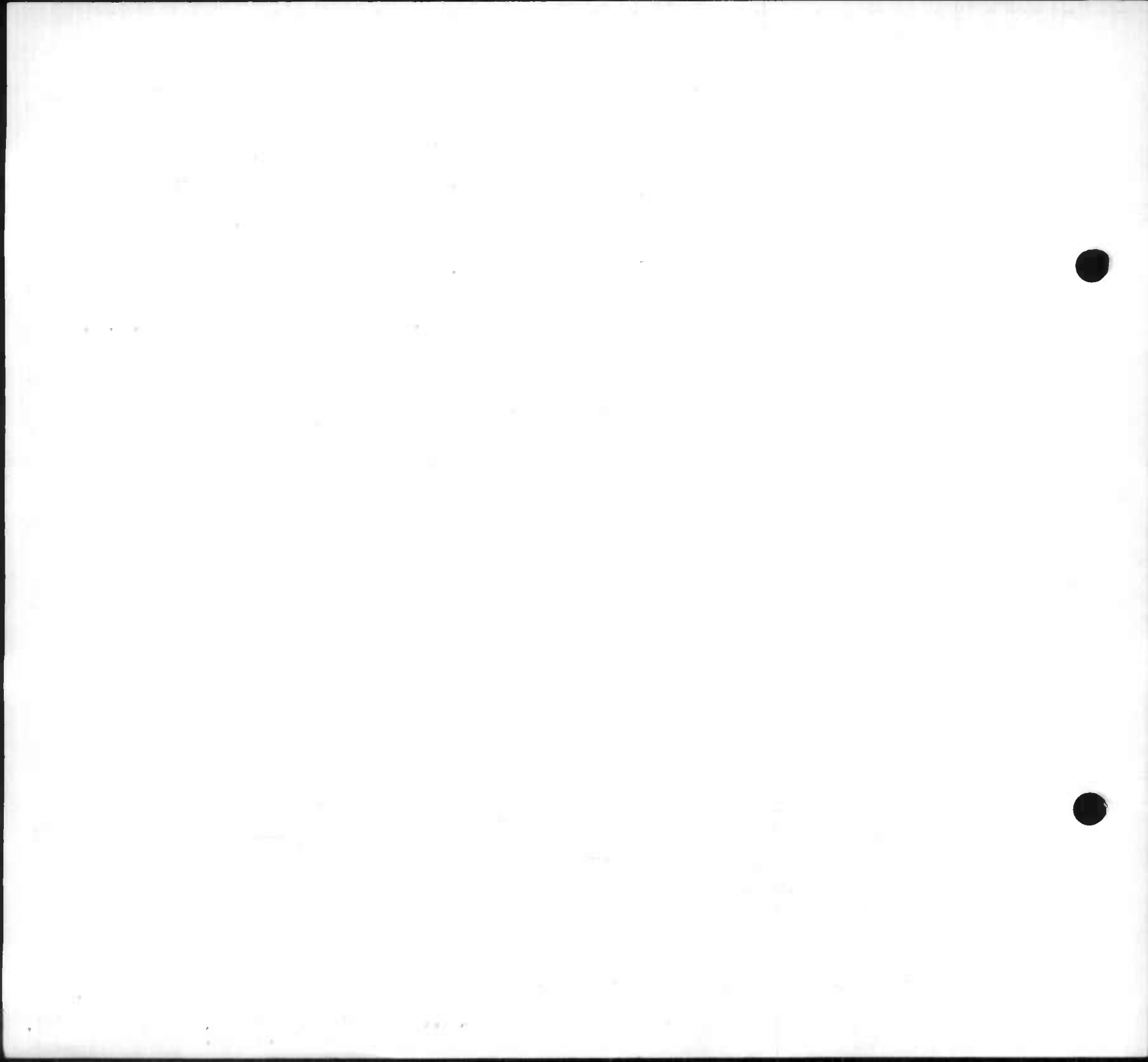
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8678</u>	
BIRTH NO. <u>P-000 71 8678</u>					
1. NAME OF DECEASED (Type or Print) <u>Miss Isabel H. Pue</u>			2. DATE AND HOUR OF DEATH <u>9-12-71</u> <u>3</u> ⁴⁰ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>91 KESWICK</u> <u>700 W. 40th. St. Balto.Md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3003 N. Charles St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27-1886</u>	9. AGE (in years last birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Howard County, Md.</u>	
13. FATHER'S NAME <u>Ferdinand Chatand Pue</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Fitzhugh Bowen</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-3494</u>		17. INFORMANT <u>Keswick Records</u>	
18. <u>412-4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CV disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1970</u> to <u>Sept. 12, 1971</u> that (I) (we) last saw the deceased alive on <u>Sept. 12, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>RK Gundry</u>			23B. DATE SIGNED <u>7-13-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Richard K. Gundry, M.D.</u>			23D. ADDRESS <u>700 W. 40th Street, Baltimore, Md. 21211</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/15/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Mark's Episcopal</u>	
24D. LOCATION <u>Highland</u>		24E. ADDRESS <u>Md.</u>		24F. ADDRESS <u>21212</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Sons Co. 4905 York Rd. Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

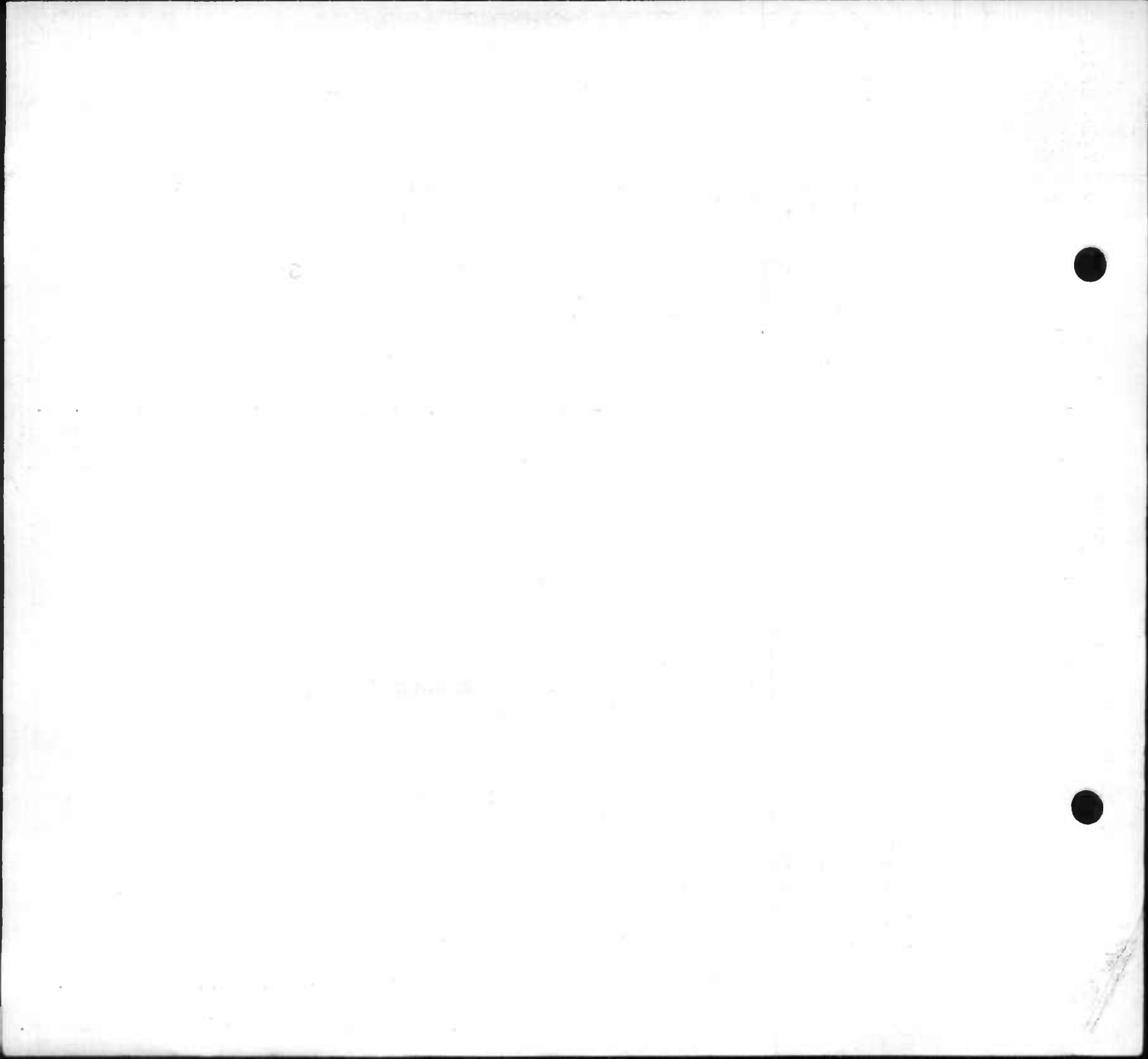
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-325 71 8679		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8679	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) AMY Biddison		2. DATE AND HOUR OF DEATH 9-13-71 7:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Florida B. COUNTY V08		C. CITY OR TOWN St. Petersburg	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 950 Snell Isle Blvd.		5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1885		9. AGE (In years lost birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME Israel		14. MOTHER'S MAIDEN NAME Eliza		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 266-76-4465		17. INFORMANT Miss Ruth Biddison (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 576.91 Pulmonary emboli		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Postop course of perforated GB 5 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9-8-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute perforate GB		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-1971 to 9-13-1971 that (I) (we) last saw the deceased alive on 9-13-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose Sagbini		23B. DATE SIGNED 9-13-71		23C. PHYSICIAN'S NAME (Type) JOSE SAGBINI MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/17/71		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore		24E. ADDRESS Smay Hospital		24F. ADDRESS Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Robert E. Scales, M.D.		25C. FUNERAL DIRECTOR M.W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd.		25E. ADDRESS Baltimore, Md. 21212		25F. ADDRESS	



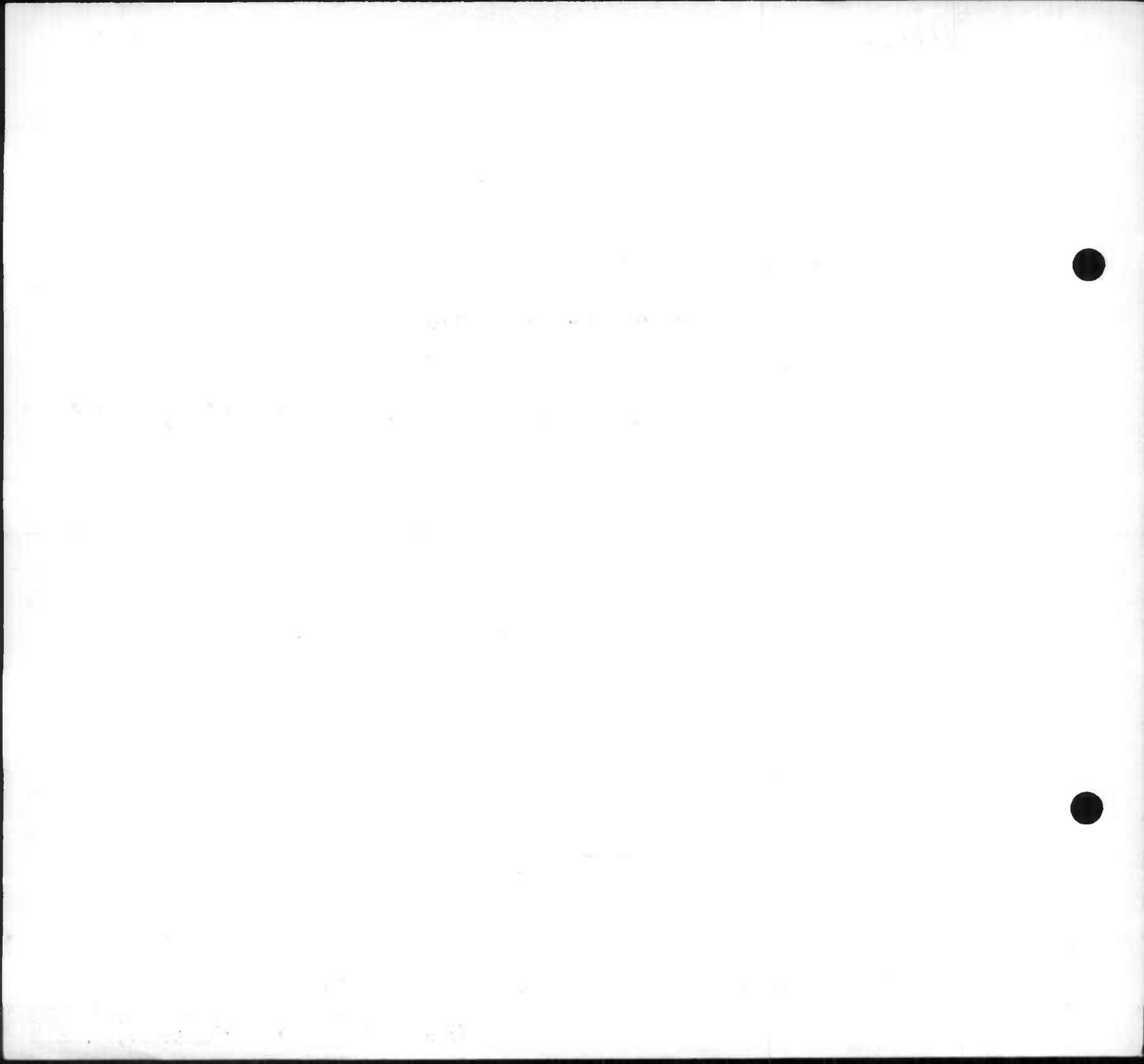
This certificate must be approved by the chief medical examiner of this jurisdiction if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71-8680	
P-400 71 8680				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Margaret Powell		2. DATE AND HOUR OF DEATH Sept 11, 1971 8:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1338		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2276 DRUID PARK DRIVE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-07	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? Yes		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-4847		17. INFORMANT Mrs. Cassie Martin-2276 Druid Pk. Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Ventricular Rupture (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest & Arrhythmia (B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Cardiovascular Disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 30 minutes	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/9/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/3/71 to 9/11/71 that (I) (we) last saw the deceased alive on 9/11/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Anderson		23B. DATE SIGNED 9/11/71		23C. PHYSICIAN'S NAME (Type) William J. Anderson	
23D. ADDRESS Johns Hopkins Hosp.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/14/71		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR J. E. J. J.		25C. FUNERAL DIRECTOR Donovan Funeral Home-3818 Roland Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 0681</u>	
<p>M-600 <u>71 8681</u></p> <p>BIRTH NO. <u>71 8681</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>ESTHER MOORE</u></p>		<p>2. DATE AND HOUR OF DEATH <u>SEPT. 7, 1971 1:00 A.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u></p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u></p> <p>C. CITY OR TOWN <u>1322 CAMBRIA ST.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1322 CAMBRIA ST.</u></p>			
<p>5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>APRIL 14, 1982</u> 9. AGE (in years last birthday) <u>89</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>Dover, Delaware</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>			
<p>13. FATHER'S NAME <u>Samuel Renshaw</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Henritta Howell</u></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>577-01-7238</u></p> <p>17. INFORMANT <u>Cynthia H. Alexander</u> ADDRESS <u>613 S. Buchanan St. Arlington, Virginia</u></p>			
<p>18. <u>250.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 MINUTES</u></p> <p>(B) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p><u>DEHYDRATION & MOD. ACIDOSIS</u></p>			
<p>19A. DATE OF OPERATION <u>NONE</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NOT APPLICABLE</u></p>		<p>20A. AUTOPSY? (Yes or No) <u>N.A.</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N.A.</u></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N.A.</u></p>	
<p>21D. TIME OF INJURY (APPROX.) <u>N.A.</u></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> N.A. Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u>N.A.</u></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 6</u> 19 <u>71</u> to <u>SEPT. 7</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>SEPT. 7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Nelson R. de Lara</u> DEGREE</p>				<p>23B. DATE SIGNED <u>SEPT. 7, 1971</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>NELSON R. DE LARA</u> DEGREE</p>				<p>23D. ADDRESS <u>SOUTH BALTIMORE GEN. HOSPITAL</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>9-10-71</u></p>		<p>24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u></p>	
<p>24D. LOCATION <u>Southland</u> (City, town, or county) (State) <u>Maryland</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u></p>			
<p>25B. NAME OF REGISTRAR <u>James H. Ad.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Murphy Funeral Home, Inc.</u> ADDRESS <u>554 Columbia Pike Arlington, Va. 22204</u></p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8682	
Z-625 71 8682			
BIRTH NO.		2. DATE AND HOUR OF DEATH EXTRACTED 9/11/71 2:4 A.M.	
1. NAME OF DECEASED (Type or Print) Zerhusen Albert J		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE BALTO B. COUNTY 5300	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 MARYLAND GENERAL HOSP.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSP.		E. STREET AND NUMBER Baker Lane	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY retiree	9. AGE (In years last birthday) 56
13. FATHER'S NAME John A. Zerhusen		11. BIRTHPLACE (State or foreign country) MD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. 216-01-6689		14. MOTHER'S MAIDEN NAME Anna B. Zellerbrock	
17. INFORMANT Woj. Picukas		ADDRESS	
18. CAUSE OF DEATH 5-74.91		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia minutes		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration pneumonia minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic pancreatitis		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic pancreatitis	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Commanded explosion - 2 months ago		(C) Chronic pancreatitis	
19A. DATE OF OPERATION 2-18-71	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric stoma	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-17-71 to 9-11-71 that (I) (we) last saw the deceased alive on 9-11-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE ASK CUSHATON		23B. DATE SIGNED 9-11-71	
23C. PHYSICIAN'S NAME (Type) ASK CUSHATON		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE SEP 14, 1971	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	24D. LOCATION (City, town, or county) (State) BALTO MD.
25A. DATE REC'D BY HEALTH DEPT SEP 15 1971	25B. NAME OF REGISTRAR Rose E. Taylor, M.D.	25C. FUNERAL DIRECTOR C. F. Evans ADDRESS 5802 Hartford Rd.	

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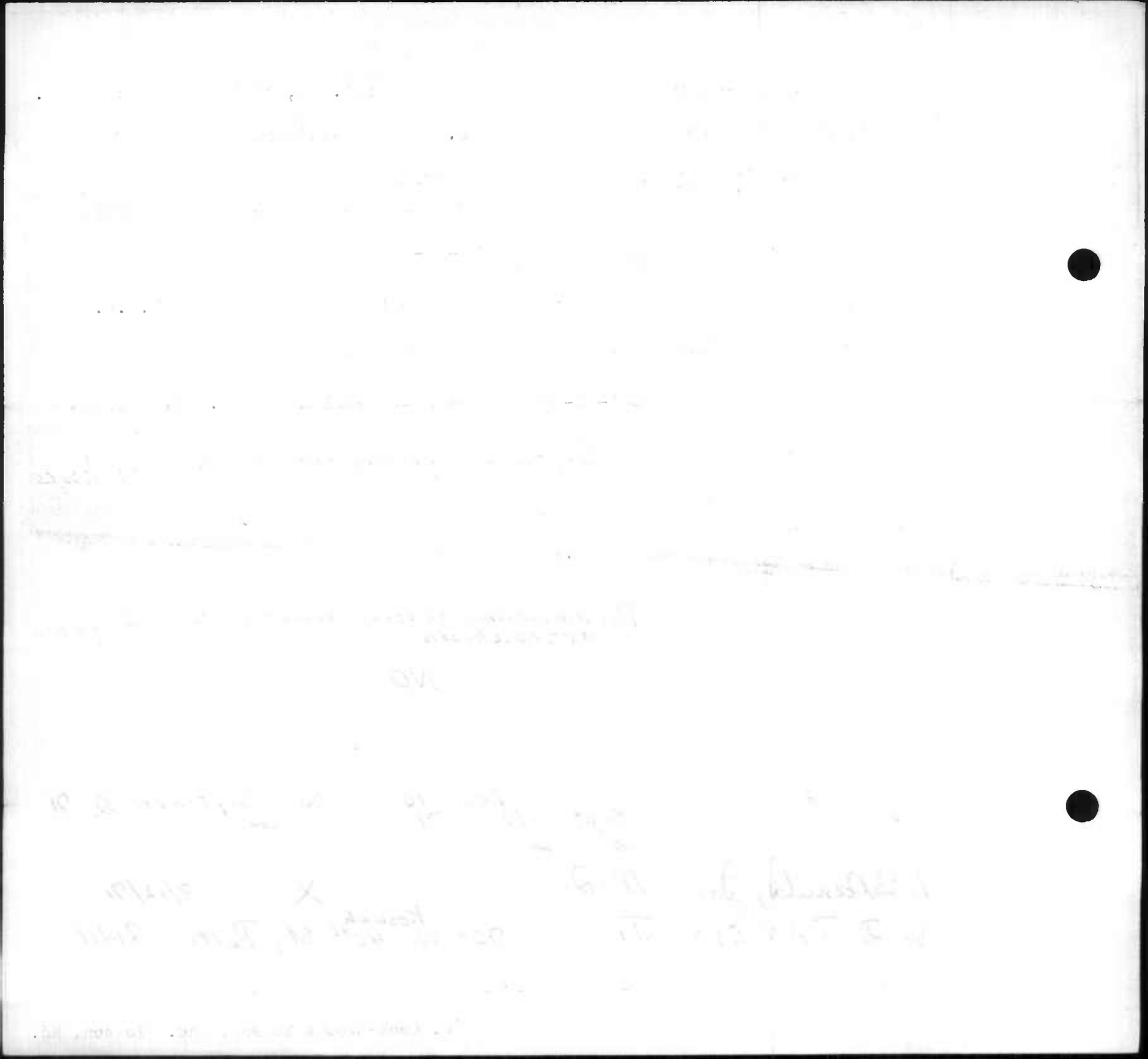
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FUNERAL DIRECTOR: IMPORTANT

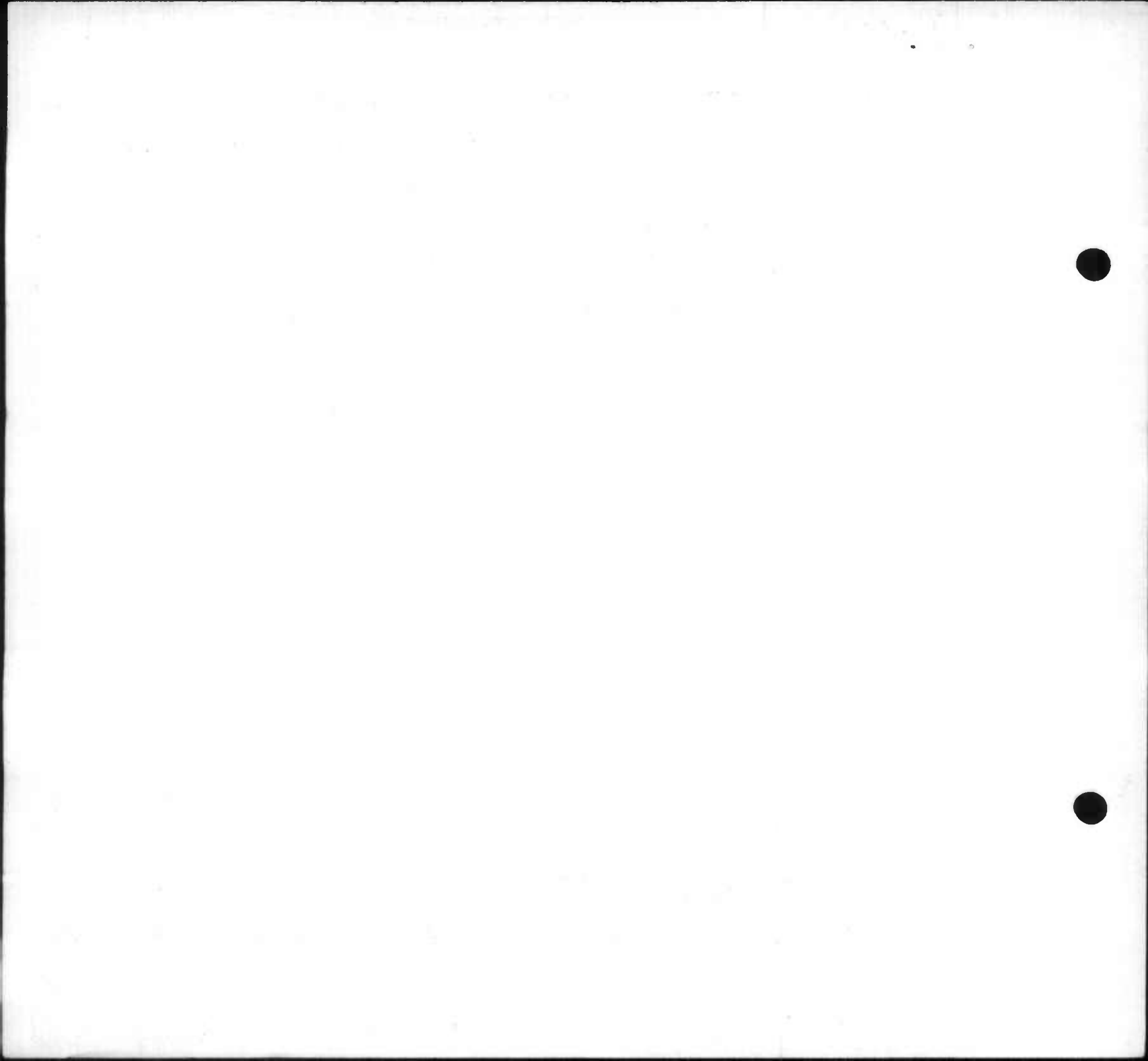
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8683</u>	
BIRTH NO. <u>7-465 71 8683</u>		2. DATE AND HOUR OF DEATH <u>Sept. 12, 1971</u> <u>7:10 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>Mary Fowler</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Keswick: Home for Incurables</u> FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL OR ADDRESS OR LOCATION) <u>700 W. 40th Street</u> <u>Baltimore, Maryland</u>		C. CITY OR TOWN <u>Timonium</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>11-20-94</u>		9. AGE (In years lost birthday) <u>76</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bradley Dewees</u>		14. MOTHER'S MAIDEN NAME <u>Laura Estes</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>545-01-5473</u>	
17. INFORMANT <u>Records: Keswick 700 W. 40th Street</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia, primary site uncertain</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Parkinsonism, severe, secondary to arteriosclerosis</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>0</u>		19A. DATE OF OPERATION <u>0</u>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>Dec. 10</u> 19 <u>70</u> to <u>September 12</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>Sept 12</u> 19 <u>71</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.			
23A. SIGNATURE <u>W.B. Daniels, Jr. M.D.</u>		23B. DATE SIGNED <u>9/12/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>W.B. DANIELS, JR.</u>		23D. ADDRESS <u>Keswick 700 W. 40th St., Balto. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>9-16-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc. Towson, Md.</u>	



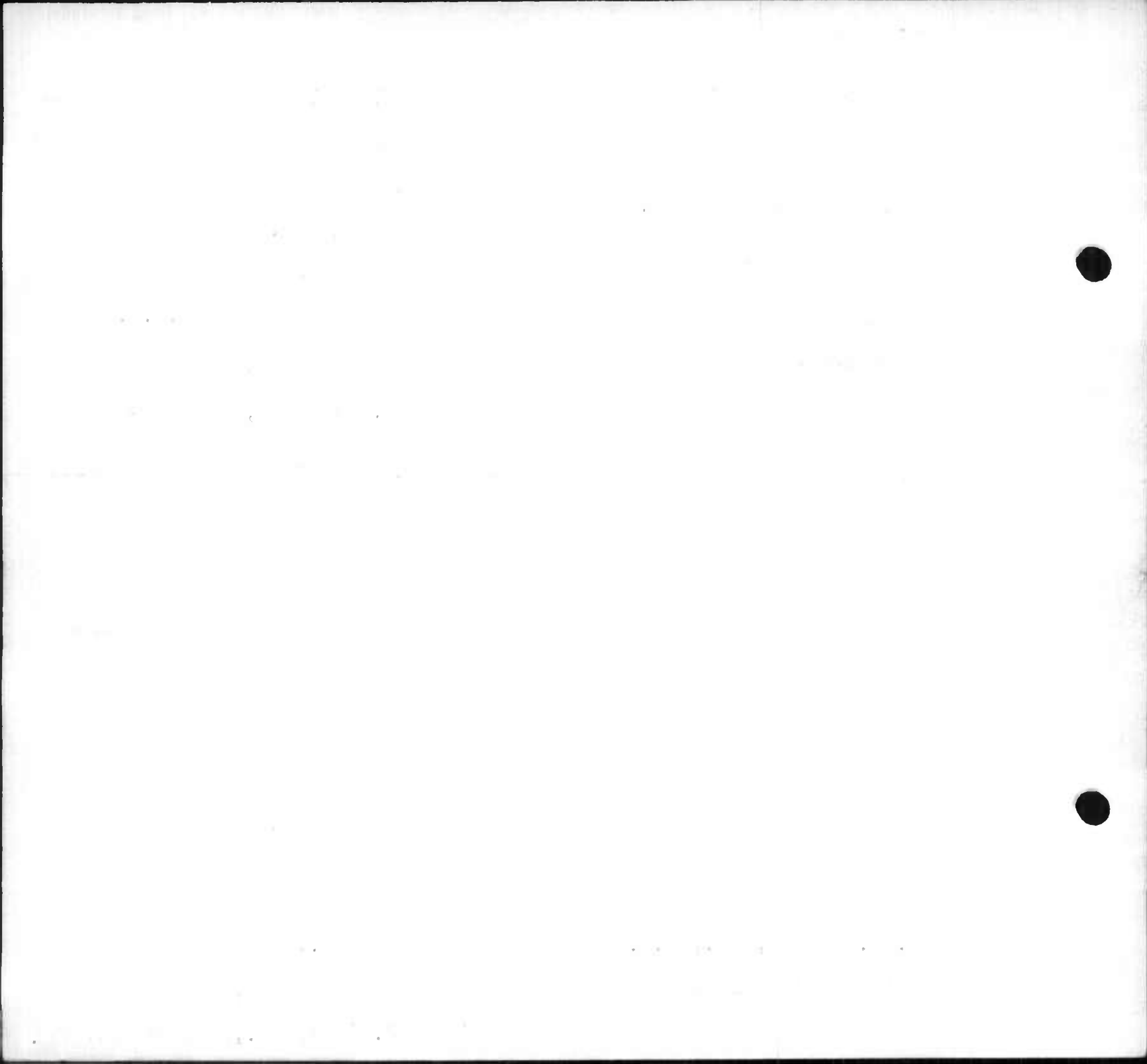
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 8684	
BIRTH NO. 71 8684				1. NAME OF DECEASED (Type or Print) Macha Otto W. SR.			
2. DATE AND HOUR OF DEATH Sept 13, 1971 4:05 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital				A. STATE MD B. COUNTY Ann Arundel 5200			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 405 CARVEL BEACH RD							
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-94	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Auto mechanic		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY US	
13. FATHER'S NAME Carl Macha				14. MOTHER'S MAIDEN NAME Olga Schuba			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 213-16-5415		17. INFORMANT Otto-Walter macha - Jr.		ADDRESS	
18. 199.01 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Generalized carcinomatosis DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 1 19 71 to Sept 13 19 71 that (I) (we) last saw the deceased alive on Sept 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruben V. Luna MD DEGREE				23B. DATE SIGNED 9-13-71		23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA MD DEGREE	
23D. ADDRESS BON SECOURS HOSPITAL							
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/15/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial PK		24D. LOCATION (City, town, or county) (State) Glen Burnie md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR R. P. Ware		ADDRESS Singleton Funeral Home/Glen Burnie, md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

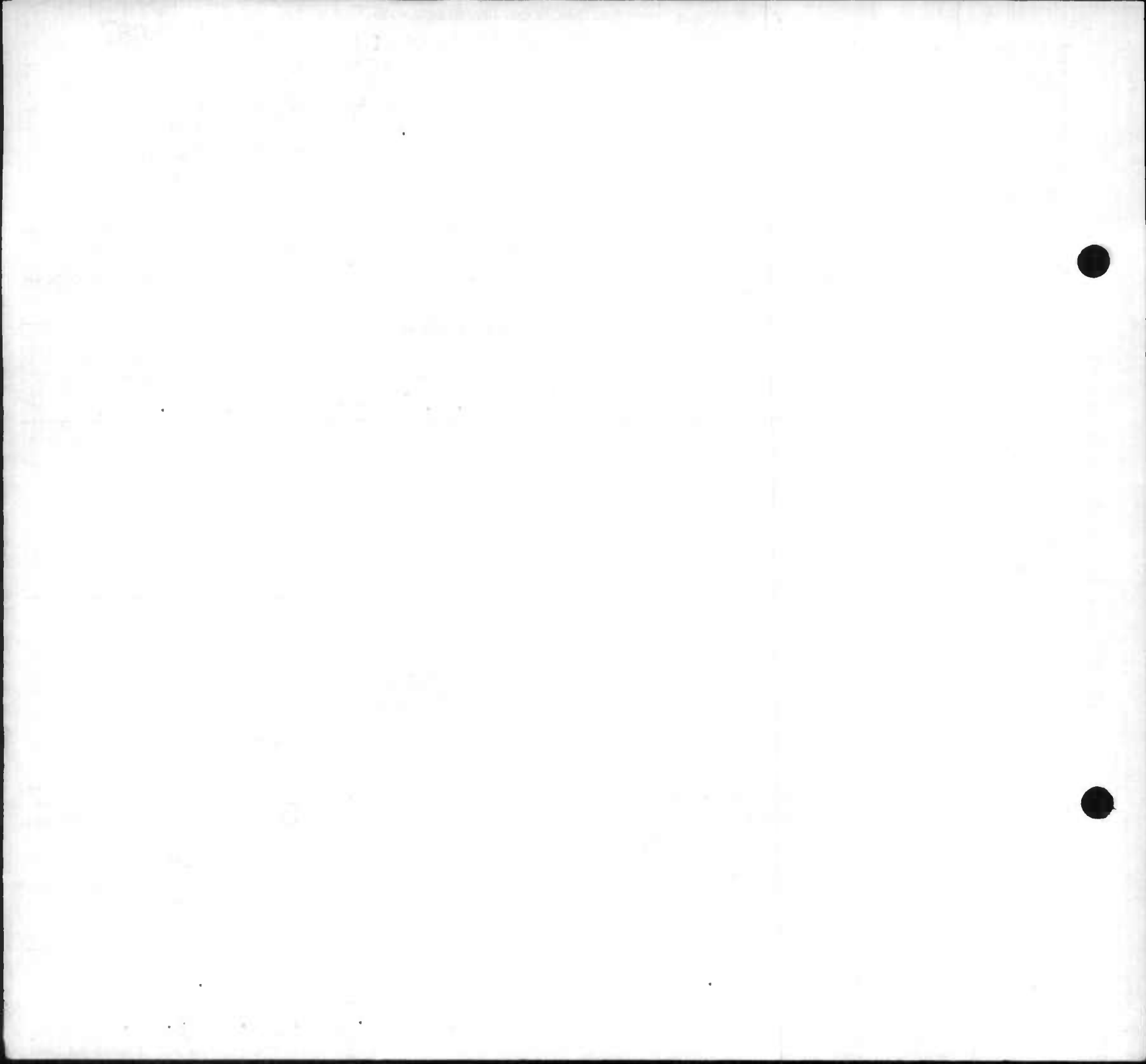
B-656 71 8685		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8685	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Rosalie Bornhorn		9/13/1971		12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 2744	
44 Union Memorial Hosp.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5527 Sefton Ave.			
5. SEX F	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1891	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Fanny		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Bernard P. Bornhorn,	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH H. arteriosclerotic - cardiac vas. dis. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Obvity -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years. 8 years.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 12, 1965 to Sept 13, 1971 that (I) (we) last saw the deceased alive on August 5, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. J. Sawyer, Jr., M.D.		23B. DATE SIGNED 9/14/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 4808 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/1971		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.,		25C. FUNERAL DIRECTOR 5305 Harford Rd.	



BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
PETER T. HAGEGEORGE		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE MARYLAND WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD	
2553 Southdene Ave. 2551 Southdene Ave.		Month Day Year Hour 9 12 1971 4:51 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
Md.		2572	
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	C. CITY OR TOWN
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Balto.
9. DATE OF BIRTH		10. AGE (In years lost birthday)	E. STREET AND NUMBER
4/28/1923		48	2551 Southdene Ave. 2553 Southdene Ave.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME
Istanbul Turkey		USA	Lazarus Hagegeorge
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME
Carrier		US POST OFFICE	Frances Klonarede
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS
No		215125453	Mrs. Aurora Hagegeorge--Same
19. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Shotgun wound of head
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20			
21. AUTOPSY? (Yes or No)		NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
2551 Southdene Ave. 2553 Southdene Ave.		Month (Day) (Year) (Hour) 9-12-71 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
		Shot self.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Russell S. Fisher, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		9/15/71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Greek Orthodox Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
SEP 15 1971		Russell S. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Leonard J. Ruck Inc.		Balto. Md. 21214	

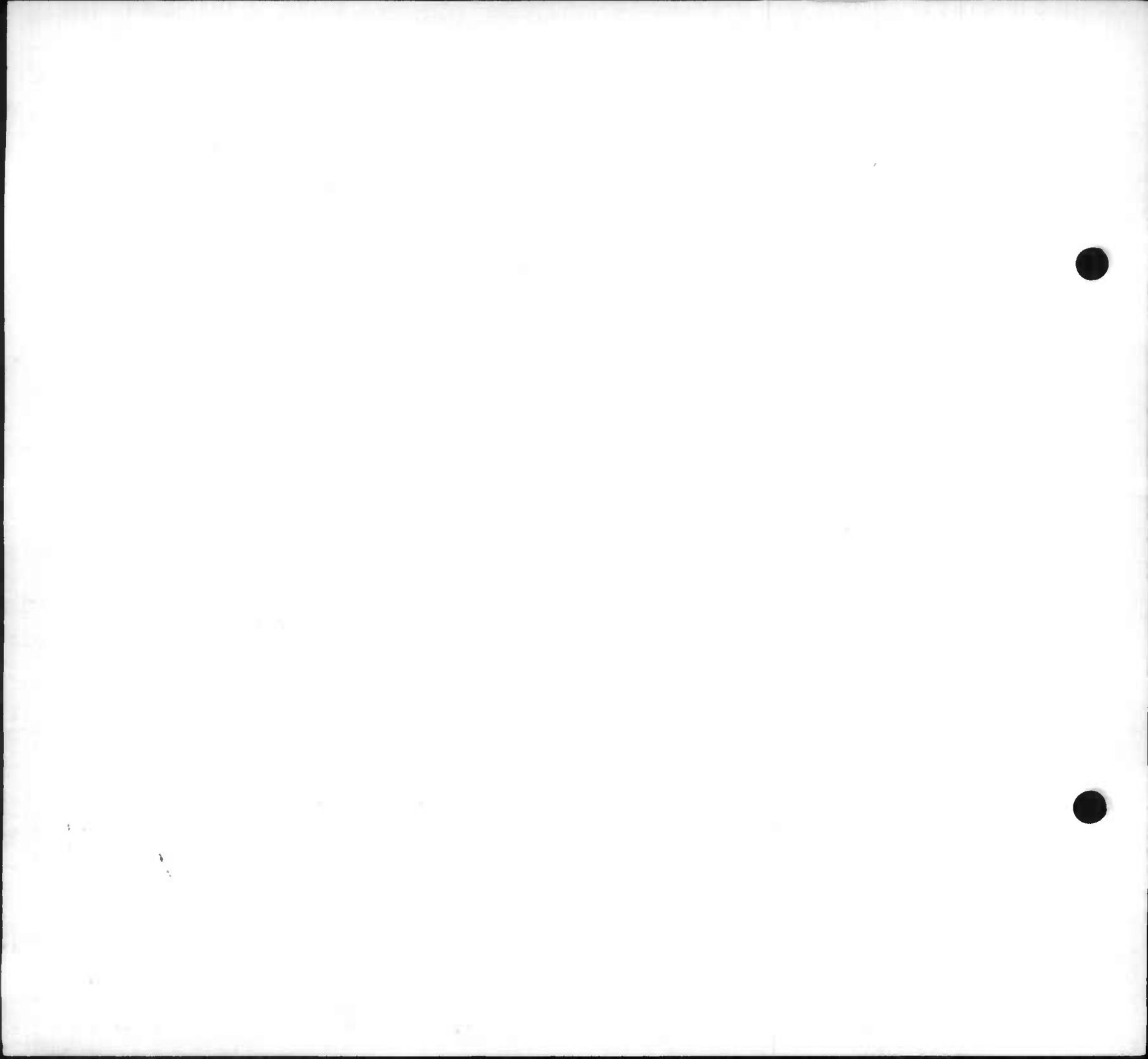
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8687	
B-656 71 8687 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LORETTA BRUNNER		2. DATE AND HOUR OF DEATH 9/12/71 8:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2743		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3087 ECHODALE AVE.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1898.	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Brunner		14. MOTHER'S MAIDEN NAME Catherine Ruth	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. E.B. Lorenz, 1139 Circle Dr. 21227	
18. 569.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CHF AND pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (B) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C) possible ischemic bowel		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 19 71 to 9/12 19 71 that (I) (we) last saw the deceased alive on 9/12 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tzen-chi Fan-Chiang				23B. DATE SIGNED 9/12/71	
23C. PHYSICIAN'S NAME (Type) TZEN-CHI FAN-CHIANG				23D. ADDRESS 33RD AND CALVERT STS. BALTIMORE 142 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 15 1971			
25B. NAME OF REGISTRAR George J. Duck, Inc.		25C. FUNERAL DIRECTOR George J. Duck, Inc. Balto. Md. 21214			

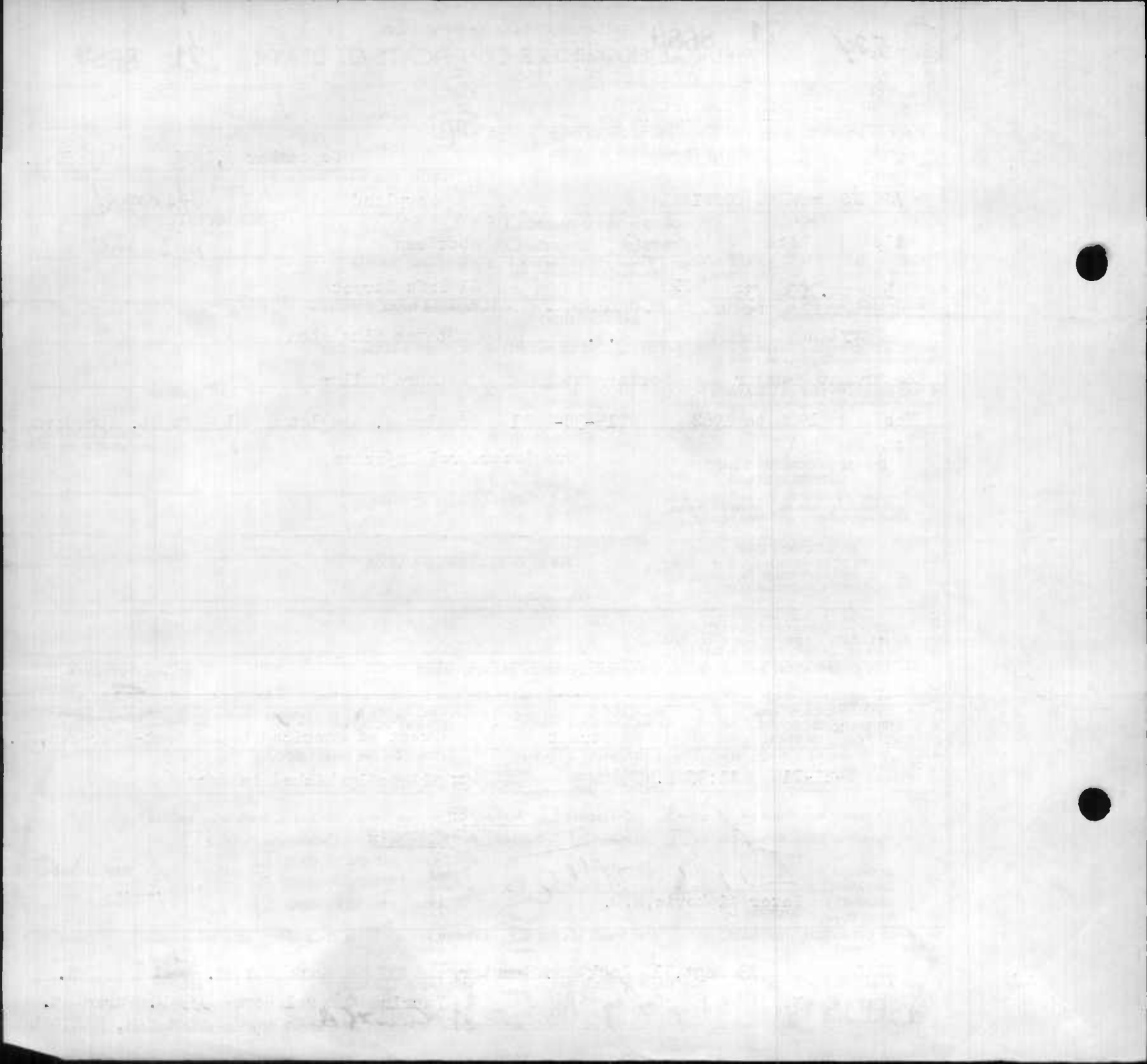


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-30071 8688		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8688	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Scott, Mrs. Thyra</u>		2. DATE AND HOUR OF DEATH <u>9-12-71</u> <u>5</u> <u>A</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>28 North Bernice Avenue</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> <u>Payette + Pulaski Sts</u> <u>Baltimore, Md. 21223</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>04-20-03</u>		9. AGE (In years last birthday) <u>68</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Honore Rikard</u>		14. MOTHER'S MAIDEN NAME <u>Bailey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-09-2470</u>		17. INFORMANT ADDRESS	
1B. <u>571-91</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>renal absorption</u>		(B) <u>? Chronic hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arrhythmia with CHF</u>		<u>unknown</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-11-71</u> 19 <u>71</u> to <u>9-12-71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-12</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>W. R. Florez</u> <u>MD</u>		23B. DATE SIGNED <u>9-12-71</u>		23C. PHYSICIAN'S NAME (Type) <u>W. R. FLOREZ</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-17-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	
24D. LOCATION <u>Baltimore</u>		24E. NAME OF REGISTRAR <u>John E. Jones</u>		24F. FUNERAL DIRECTOR <u>John E. Jones</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 15 1971</u>		25B. NAME OF REGISTRAR <u>John E. Jones</u>		25C. FUNERAL DIRECTOR <u>John E. Jones</u>	



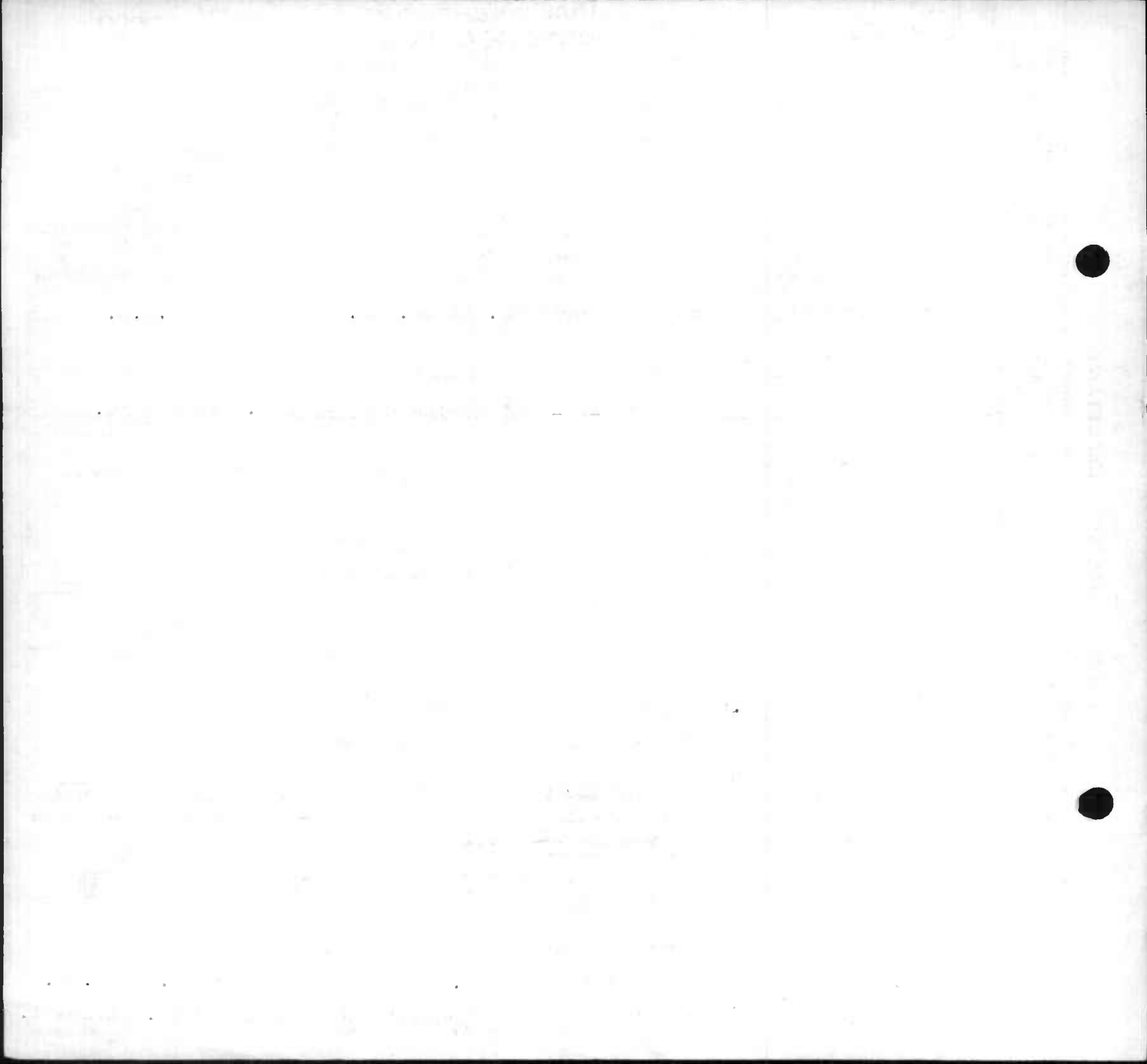
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8689			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO. S-524 71 8689							
1. NAME OF DECEASED (Type or Print) KENNETH SINGLETON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1971 11:50 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5 Sept. 1936				10. AGE (in years last birthday) 35		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Steven Singleton		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Manager	
15. MOTHER'S MAIDEN NAME Laura Cullum				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1960 to 1962		17. SOCIAL SECURITY NO. 215-32-7421	
18. INFORMANT Rosalee A. Singleton				19. ADDRESS 41 Taft St. Aberdeen		20. DATE OF OPERATION 2	
21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		23. AUTOPSY? (Yes or No) yes	
24. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of American Legion Post-Aberdeen, MD.	
27. TIME OF INJURY (APPROX.) 8-21-71 11:45 P.M.				28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		29. HOW DID INJURY OCCUR? Allegedly kicked in face	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				30. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		31. DATE SIGNED 9/10/71	
32. BURIAL CREMATION, REMOVAL (Specify) BURIAL				33. DATE 13 Sept. 71		34. NAME OF CEMETERY or CREMATORY Rock Run Cemetery	
35. DATE REC'D BY HEALTH DEPT. SEP 15 1971				36. NAME OF REGISTRAR Robert E. Taylor, M.D.		37. FUNERAL DIRECTOR Tarring Funeral Home	
38. ADDRESS 333 S. Parke St. ABERDEEN, MARYLAND				39. ADDRESS 41 Taft St. ABERDEEN, MARYLAND		40. ADDRESS 41 Taft St. ABERDEEN, MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

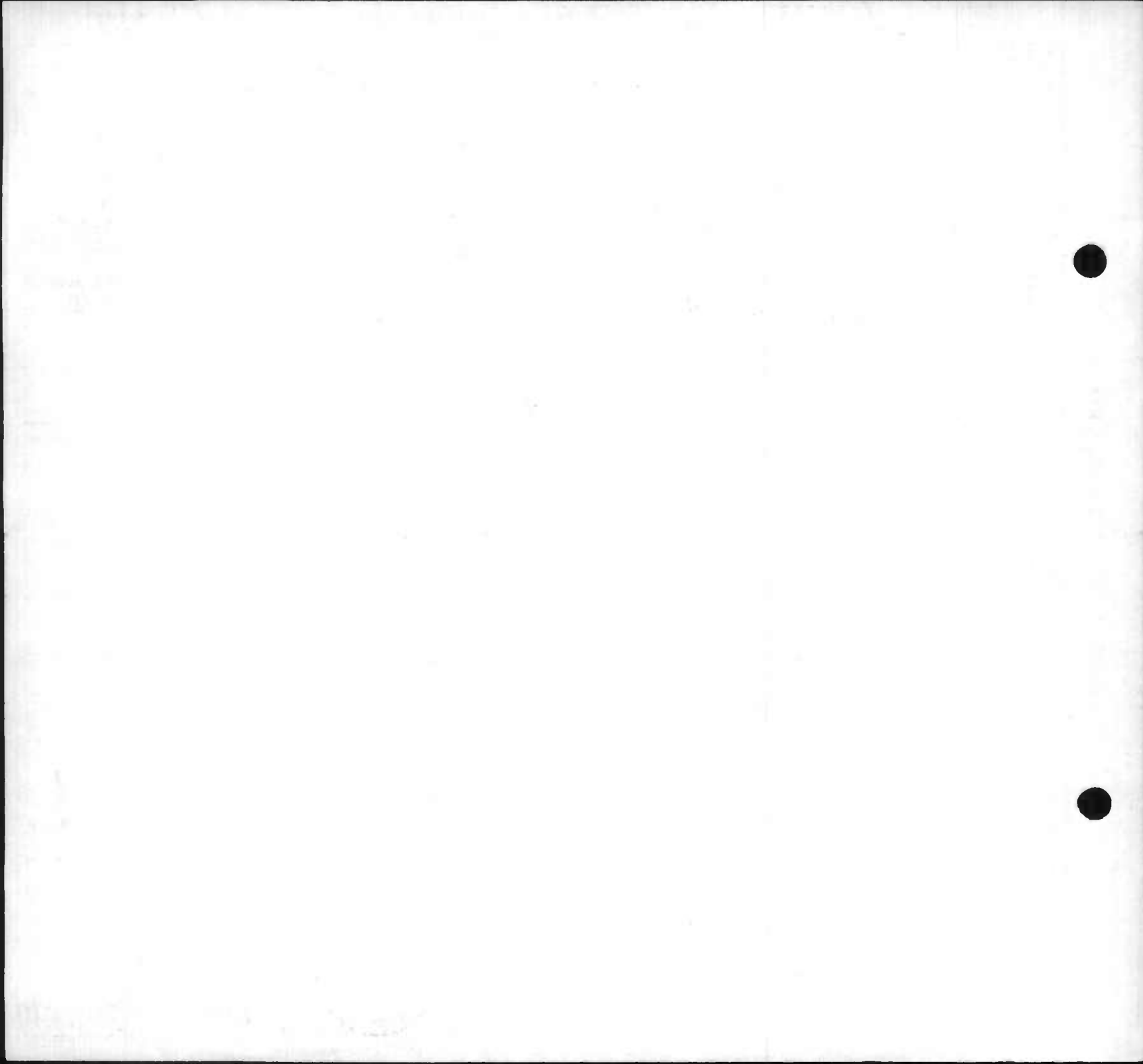
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8690	
0-550 71 8690					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Miss Anne O'Mahony</u>			2. DATE AND HOUR OF DEATH <u>9/11/71</u> <u>6:35</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2301</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>9 W. Clement St.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-1891</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas & Electric Co. Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. O'Mahony</u>			14. MOTHER'S MAIDEN NAME <u>Marie King</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-4067</u>		17. INFORMANT <u>Regina Griffin</u> ADDRESS <u>9 W. Clement St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Competitive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>degen</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Week</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Weak</u>			<u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Years</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/11</u> 19 <u>71</u> to <u>9/11</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>9/11</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Claudio KLINT</u> DEGREE				23B. DATE SIGNED <u>9/11/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Claudio KLINT</u> DEGREE				23D. ADDRESS <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/15/71</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		24E. LOCATION (City, town, or county) (State) <u>Old Frederick Rd. Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1971</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Krause</u>	
25D. ADDRESS <u>1216 S. Charles St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

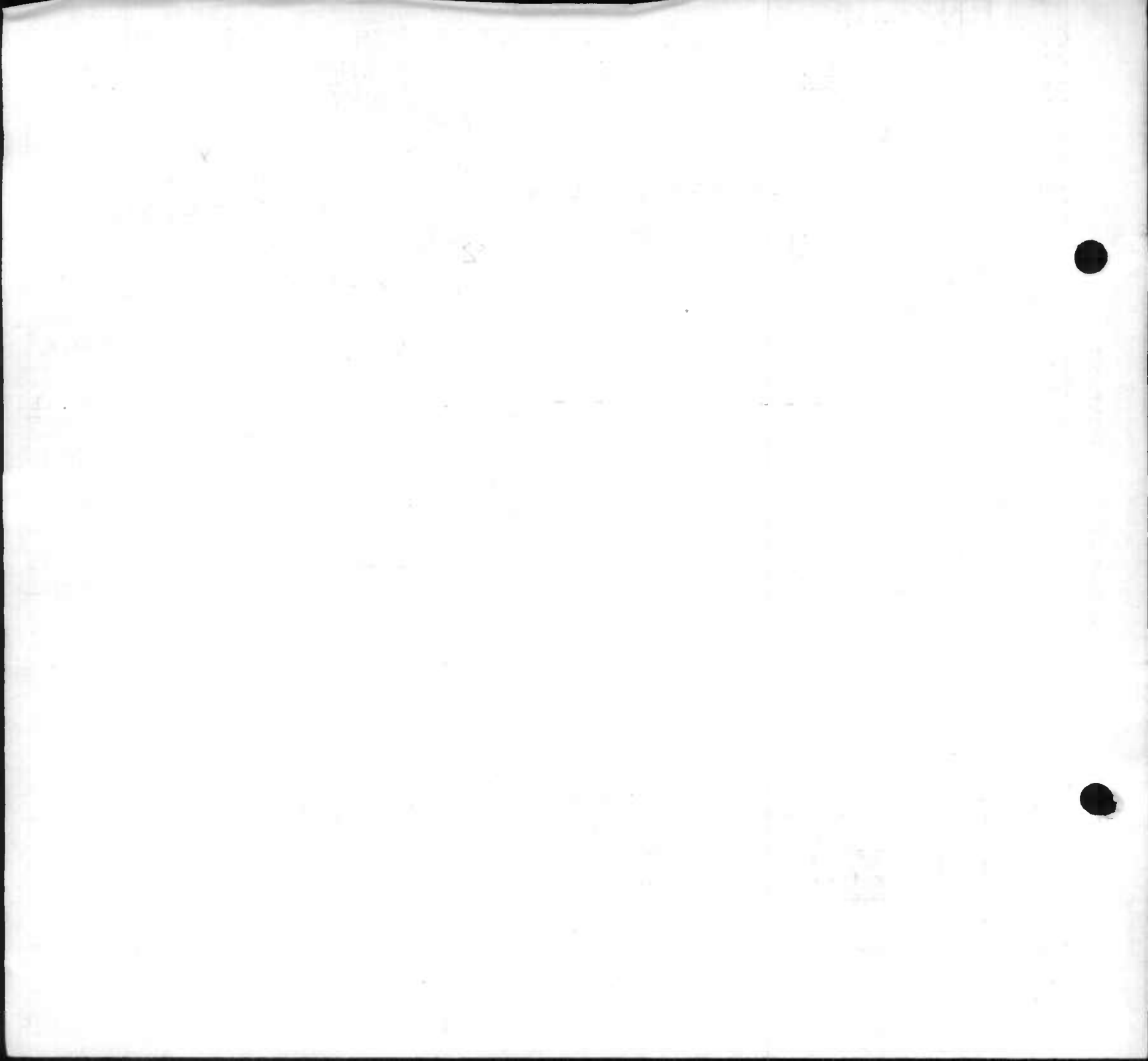
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.		71 8691	
BIRTH NO. 11-230 71 8691				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) MUSTOE E. HERBERT				2. DATE AND HOUR OF DEATH 9-13-71 3:16 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.					
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1702 LANGLEY ROAD				21221					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Maker			10B. KIND OF BUSINESS OR INDUSTRY Martins' Aircraft			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR MUSTOE				14. MOTHER'S MAIDEN NAME EDNA EGGLESTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-12-2141		17. INFORMANT Mrs Aletha Mustoe		ADDRESS Same	
18. 519.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CHRONIC OBSTRUCTIVE LUNG DISEASE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-27 19 71 to 9-13 19 71 that (I) (we) last saw the deceased alive on 9-13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jose A. Paz				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9-13-71			
23C. PHYSICIAN'S NAME (Type) JOSE PAZ				23D. ADDRESS THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 16 Sept 71		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR John E. Kelly, M.D.		25C. FUNERAL DIRECTOR Burgeo Funeral Home		ADDRESS Balto, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8692</u>
BIRTH NO. <u>K-500</u>		71 8692		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Kane, Lewis F</u>		2. DATE AND HOUR OF DEATH <u>9/14/71</u> <u>11:50 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2714</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Roland - Heights Ave 1142</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/06</u>	9. AGE In years <u>65</u> lost birthday <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Casualty Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Kane</u>		
14. MOTHER'S MAIDEN NAME <u>Weeks, Martha</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-05-7870</u>		17. INFORMANT <u>Mrs. Evelyn Kane</u> ADDRESS <u>1142 Roland Hgts. 11</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic lung disease</u>		CAUSE OF DEATH <u>acute pulmonary myocard infection.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic lung disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>C & F</u> (C) <u>?</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>month - yrs</u>
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>9/8/71</u> to <u>9/14/71</u> that (I) (we) lost saw the deceased alive on <u>9/14/71</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Charles F. ...</u>		23B. DATE SIGNED <u>9/14/71</u>		23C. PHYSICIAN'S NAME (Type) <u>E. FAZEKAS</u>
23D. ADDRESS <u>M.D. U. M. H.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>9/17/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1971</u>		25B. NAME OF REGISTRAR <u>John E. ...</u>		25C. FUNERAL DIRECTOR <u>Donovan Funeral Home</u>
ADDRESS <u>3818 Roland Ave</u>				



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8693

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Paul Finkelstein

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
 9 14 71 3:52 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
 FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
 9 14 71 3:52 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 A. STATE B. COUNTY

Maryland

B. COUNTY

2730

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

April 6 1905

10. AGE (In years lost birthday) 66

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

6410 Elray Drive

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Morris M.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bessie

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

217-09-4937

18. INFORMANT

Neap Char

ADDRESS

19. E881X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Craniocerebral injuries
 DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
 Building

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
 Chase & Pleasant Street

401

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8 30 71

22E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?
 Fell from ladder

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-14-71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/15/71

24C. NAME of CEMETERY or CREMATORY

Shoarei Zion

24D. LOCATION (City, town, or county)

Balto

(State)

md

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1971

25B. NAME OF REGISTRAR

Isabel E. Taylor, M.D.

25C. FUNERAL DIRECTOR:

Sylvan Lewis

ADDRESS

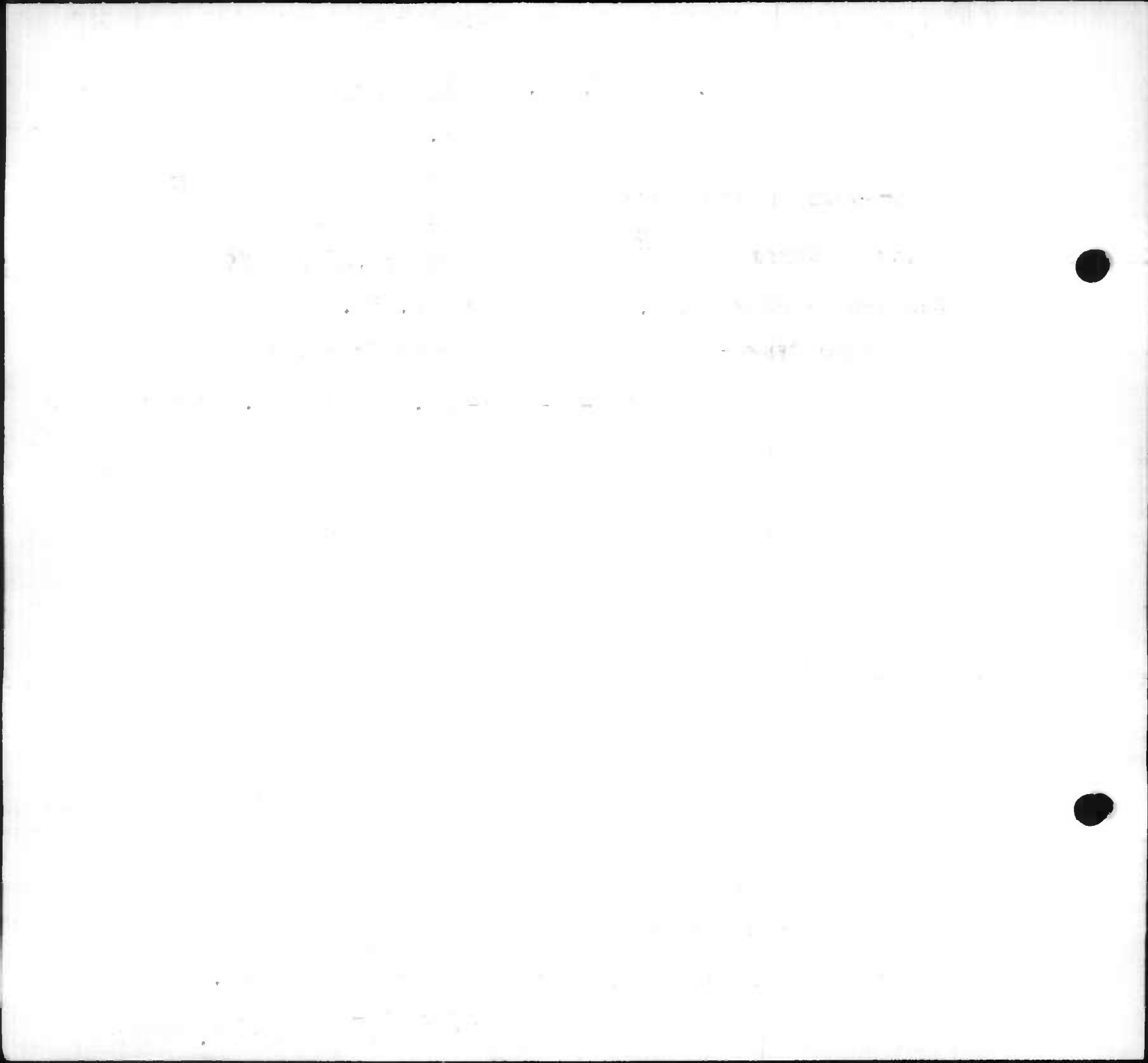
960 Reisterstown Rd

3/10/72 - Marriage record. Paul Finkelstein and Sadié Kolodner.
D.M. 6/25/1933. Folio: 102. Docket 1933. *L. F. Carter*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

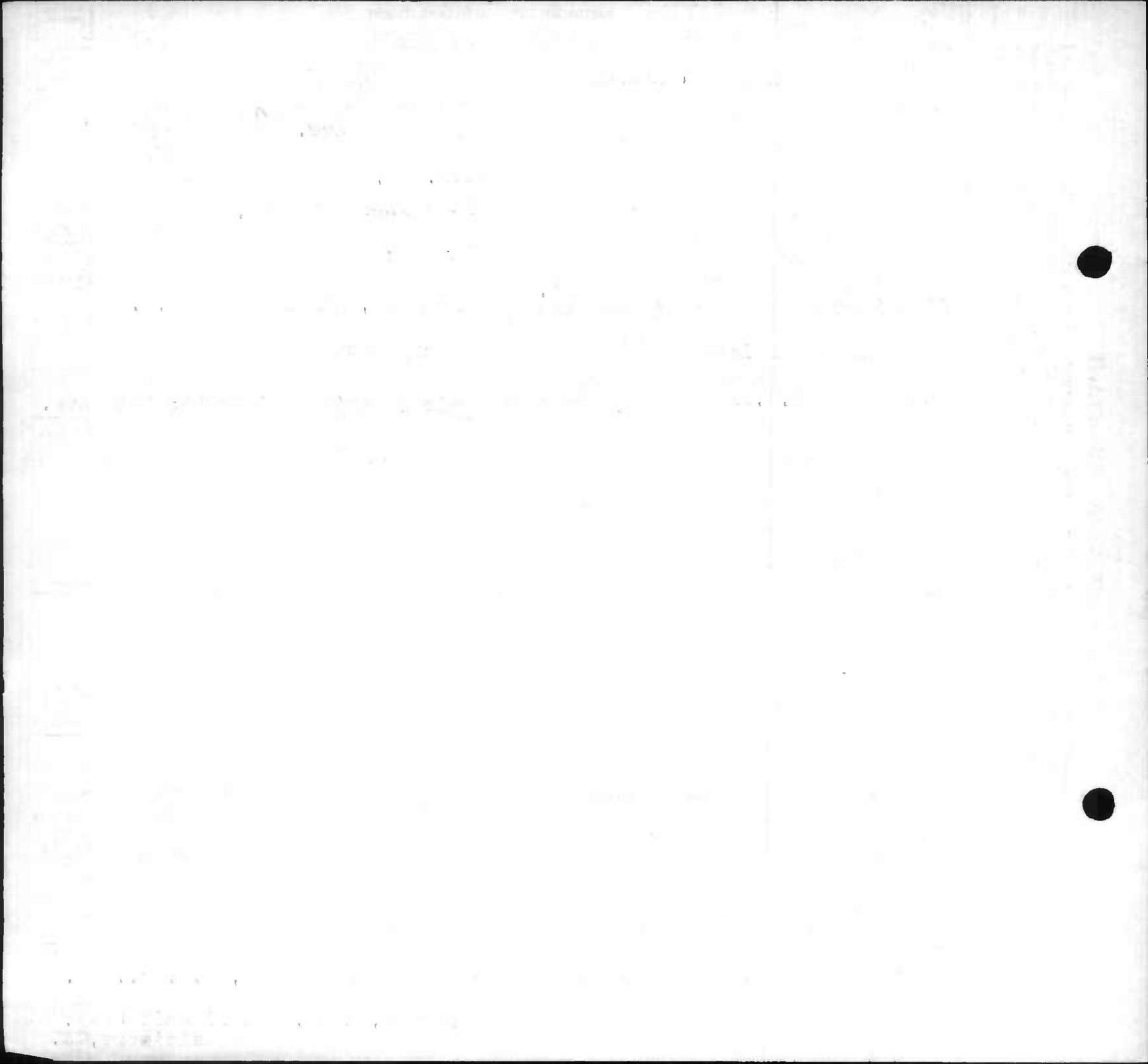
C-300 71 8694		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 8694 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES J. CIOTTI, SR.		2. DATE AND HOUR OF DEATH 9/10/71 4 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 70 EDGEWOOD NURSING HOME		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3601 GREENWAY		5. SEX MALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 4TH, 1899		9. AGE (In years) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MORTGAGE BANKING		10B. KIND OF BUSINESS OR INDUSTRY (RET.)		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME ANDREW CIOTTI		14. MOTHER'S MAIDEN NAME AGNES VINCENTI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-36-6587		17. INFORMANT MRS. MARGARET E. CIOTTI - same	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior Sclerotic Heart Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Parkinson's Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Vascular Sclerosis		3 yrs.	
(C) Generalized Vascular Sclerosis				5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 25, 1958 to Sept. 10, 1971 that (I) (we) last saw the deceased alive on Aug. 31, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Earl L. Chambers, M.D.		23B. DATE SIGNED 9/13/71			
23C. PHYSICIAN'S NAME (Type) EARL CHAMBERS		23D. ADDRESS 100-W - Cold Spring La. Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/14/71		24C. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO MD.					
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR MITCHELL		25C. FUNERAL DIRECTOR WIEDEFELD HOME	
25D. ADDRESS 6500 YORK RD. 21212					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8695</u>
BIRTH NO. <u>A-652 71 8695</u>		1. NAME OF DECEASED (Type or Print) <u>CHARLES J. ARMIGER</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		2. DATE AND HOUR OF DEATH <u>9-11-71</u>		
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Firefighter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Baltimore Fire</u>		8. DATE OF BIRTH <u>5-10-21</u>
13. FATHER'S NAME <u>Joseph Armiger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or days of service) <u>Yes W.W.II</u>		16. SOCIAL SECURITY NO. <u>212 07 1764</u>		17. INFORMANT <u>Daisey Marie Armiger/318 14th Ave.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>AS coronary artery disease.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>(Presumably had recurrent myocardial infarct. or</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>V.T. or V. fibrillation.</u> (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>9/14/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>71</u> to <u>death</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>7/14/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>L.F. Cwale</u>		23B. DATE/SIGNED <u>9/12/71</u>		23C. PHYSICIAN'S NAME (Type) <u>L.F. AWALT</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/14/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A.A.Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1971</u>		
25B. NAME OF REGISTRAR <u>971000</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce, 4001 Ritchie Hwy. Baltimore, Md.</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8696

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN C. WHEELER

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1722 Poplar Grove Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

September 14, 1971 7:10 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1506

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

12/12/43

10. AGE (In years
last birthday)

27

11. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1722 Poplar Grove Street

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Wheeler

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14b. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosa Jane

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

216-42-4846

18. INFORMANT

ADDRESS

Willie J. Wheeler 1104 McKeane Ave.

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Fatty metamorphosis of liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/18/71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 16 1971

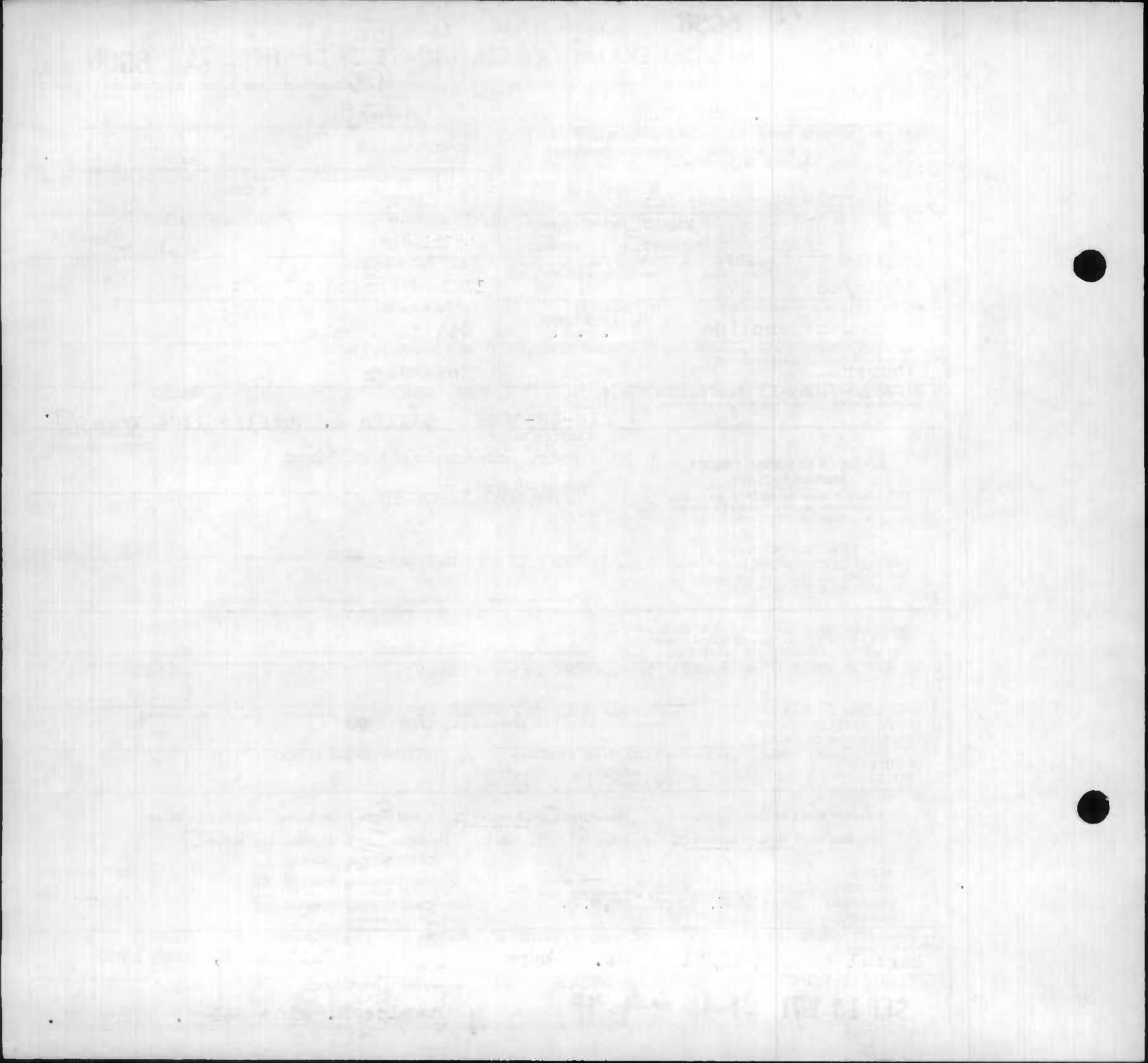
25B. NAME OF REGISTRAR

Patricia E. Fisher, R.D.

25C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

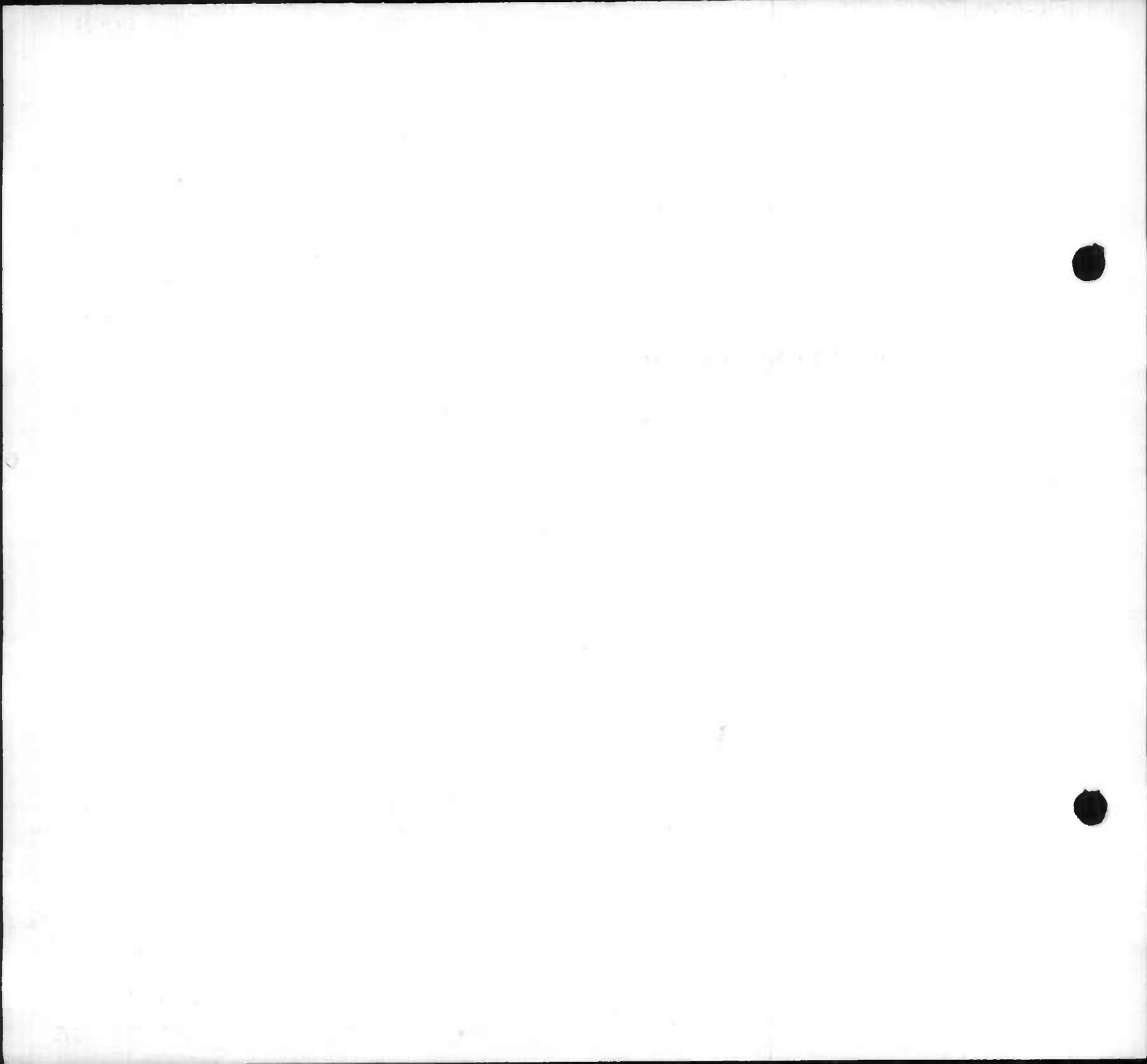
<p>W-524 71 8697</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8697</p>	
<p>BIRTH NO. _____</p>		<p>2. DATE AND HOUR OF DEATH 9/12/71 2:26 P.M.</p>	
<p>1. NAME OF DECEASED (Type or Print) William Winslow</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1701</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University of Maryland Hospital</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 538 W. Mulberry St.</p>	
<p>5. SEX Male</p>	<p>6. RACE Black</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11-27-91</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) charlter (retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) 79</p>
<p>11. BIRTHPLACE (State or foreign country) Washington, D.C.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.</p>	
<p>13. FATHER'S NAME William Winslow</p>		<p>14. MOTHER'S MAIDEN NAME unknown</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>16. SOCIAL SECURITY NO. 578-12-3800</p>	<p>17. INFORMANT ADDRESS Naomi Barham 121 56th place SE. Wash. D.C.</p>
<p>18. 599.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Septicemia DUE TO, OR AS A CONSEQUENCE OF: (C) Urinary tract infection</p>	
<p>19. DATE OF OPERATION 9/12/71</p>		<p>20. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9/12/71</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 8/11 1971 to 9/12 1971 that (I) (we) lost saw the deceased alive on 9/12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Robert E. Greenspan, M.D.</p>		<p>23B. DATE SIGNED 9/12/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Robert E. Greenspan; M.D.</p>		<p>23D. ADDRESS 829 Hollins St., Baltimore, Md. 21201</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 9/16/71</p>	<p>24C. NAME of CEMETERY or CREMATORY Lincoln Memorial Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Maryland</p>
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Greenspan, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Stewart Funeral Home</p>		<p>25D. ADDRESS 4001 Benning Rd. N.E.</p>	

Information Sex & Race By Phone. Dr. Greenspan. University Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40-01-18		BALTIMORE CITY HEALTH DEPARTMENT		71 8698	
P-412		71 8698		REG. NO. 71 8698	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mr. LEO PHILLIPS		Sept 13, 1971 10:40 pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 300 S. SPRING COURT 21231	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-07	9. AGE (in years lost birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlos THOMAS PHILLIPS			14. MOTHER'S MAIDEN NAME Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-12-0935		
			17. INFORMANT 4940 Eastern Avenue ADDRESS BCH: Records Baltimore, Maryland 21224		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 519.3 I CARDIO PULMONARY ARREST ONE MONTH					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) RECURRENT PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF:					
(C) OBSTRUCTIVE LUNG DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Aug 1, 1971 to Sept 13, 1971 that (2) (we) lost saw the deceased alive on Sept 13, 1971 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE A. MAKARY				23B. DATE SIGNED Sept 13, 1971	
23C. PHYSICIAN'S NAME (Type) A. MAKARY				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-16-71		24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEMETERY	
BURIAL				24D. LOCATION (City, town, or county) (State) DUNNALK MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR John M. Wierzbicki		25C. FUNERAL DIRECTOR JOHN M. WIERZBIKSONS INC 4015 CHESTER ST.	



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F630

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8699

71 8699
REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES FORD, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 942 E. Biddle St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 13 1971 8:55 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9-11-12		10. AGE (in years last birthday) 59	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-05-6305	
18. INFORMANT LEON FORD		ADDRESS 3322 SPALDING AVE	
19. 571-81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-16-71	
24C. NAME OF CEMETERY or CREMATORY Mt. CALVARY CEM		24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CTY MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR JAMES MARCH		ADDRESS 928 E NORTH AVE	

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D620

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8700

71 8700

1. NAME OF DECEASED (Type or Print) ALFRED L. DORSEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2414 St. Paul Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 9, 1971 10:50 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1206	
9. DATE OF BIRTH AUG. 18, 1907		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. DORSEY		14. MOTHER'S MAIDEN NAME SADIE KING	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDYMAN		14B. KIND OF BUSINESS OR INDUSTRY GOVE FUNERAL HOME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 215-03-4324	
18. INFORMANT MR WILSON W. DORSEY		ADDRESS BALTIMORE, MD. 5710 WOODCREST AVE.	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION D		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 9, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE SEPT. 13, 1971	
24C. NAME OF CEMETERY OR CREMATORY WOODHAWN CEMETERY		24D. LOCATION (City, town, or county) (State) WOODHAWN BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR STANLEY H. NEWELL		ADDRESS BALTIMORE, MD.	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 8701

BIRTH NO. 71 8701

1. NAME OF DECEASED
(Type or Print)

MARGARET J. HARRIS

2. DATE AND HOUR OF DEATH

9/15/71

3:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

Worcester

7300

C. CITY OR TOWN

Pocomoke

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

Route 2, Box 12.

5. SEX

Fem

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-11-23

9. AGE (in years
last birthday)

48

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

Crown-Corkand Seal

11. BIRTHPLACE (State or foreign country)

Baltimore

, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Horvath

14. MOTHER'S MAIDEN NAME

Augusta Marasky

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-20-0230

17. INFORMANT

William B. Harris

ADDRESS

Same.

18. 531.01

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Hepatic failure with G I bleeding

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Gastric Ulcer

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1 8/23/71

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Gastric Ulcer

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

NO

21C. WHERE DID
INJURY OCCUR?

NO

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

NO

21E. INJURY OCCURRED

NO

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

NO

22. I certify that (I) (this hospital) attended the deceased from 8/12 1971 to 9/13 1971
that (I) (we) last saw the deceased alive on 9/14 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harold J. Kaplan

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

9/15/71

23C. PHYSICIAN'S
NAME (Type)

HAROLD J. KAPLAN

23D. ADDRESS

Mercy Hospital, Balto., Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-18-71.

24C. NAME OF CEMETERY or CREMATORY

Sunnyridge Cemetery

24D. LOCATION

Crisfield, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

9/16/71

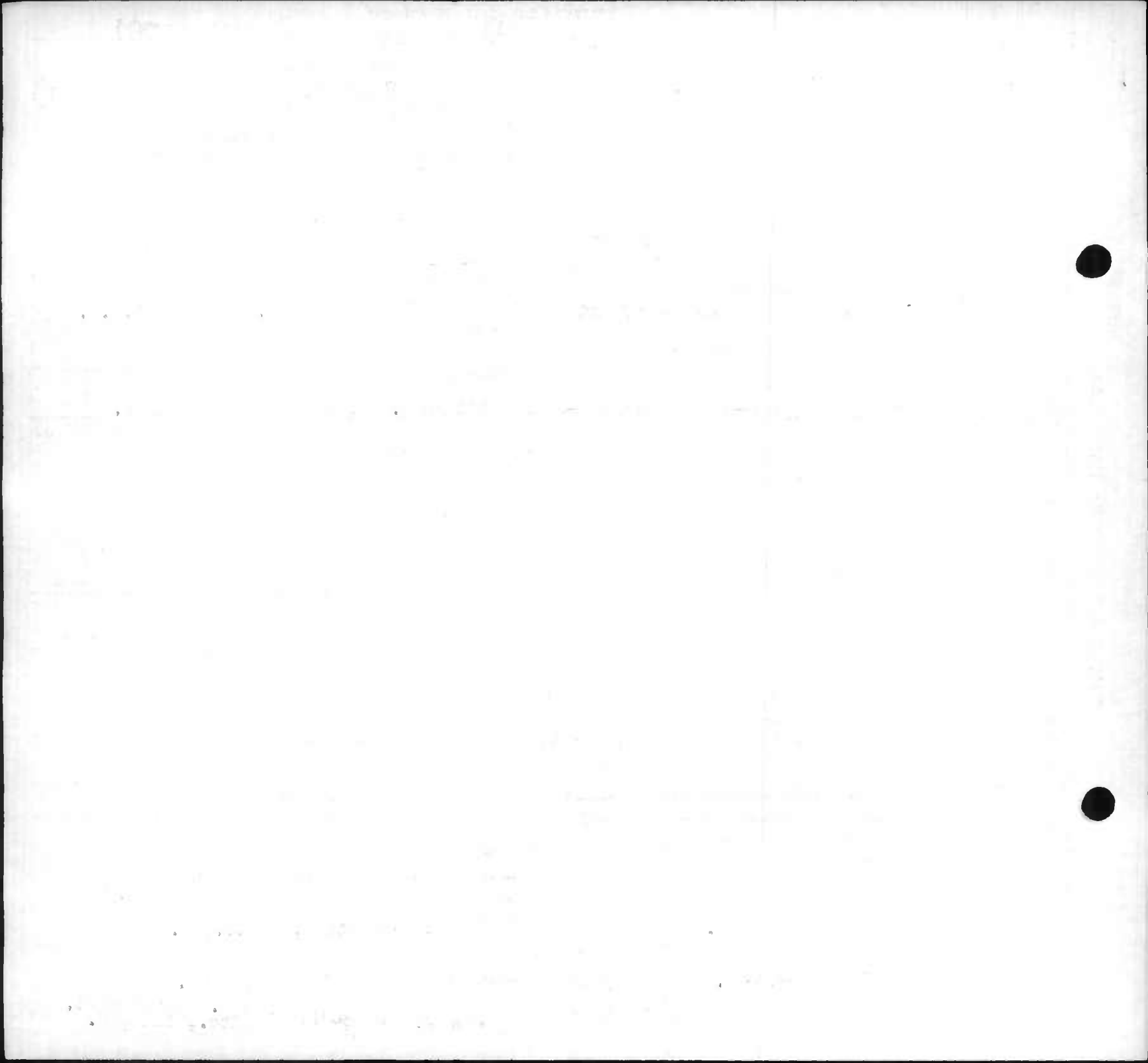
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Charles S. Guler

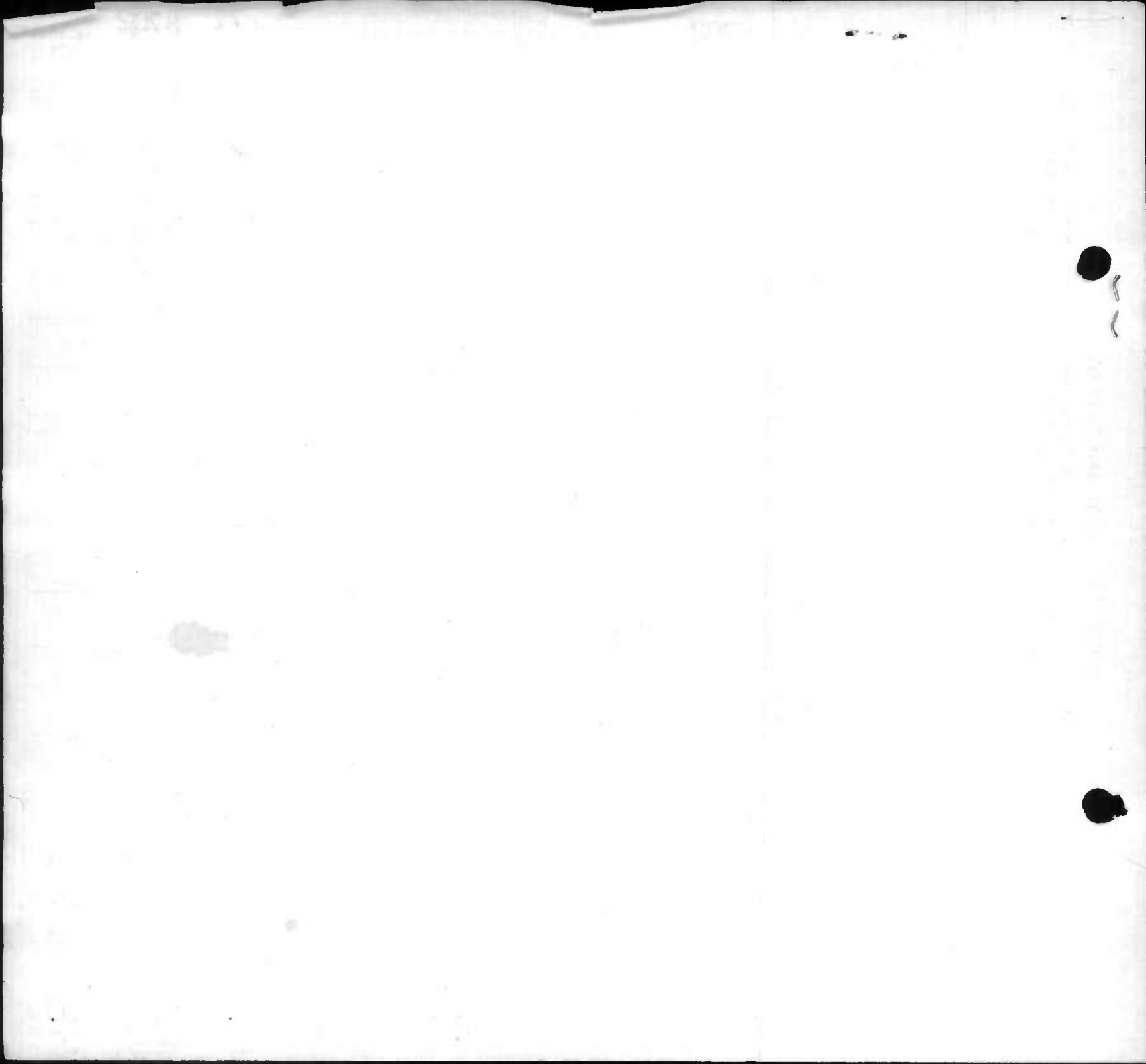
901 S. Conkling St.
Balto., 21224, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8702	
7-456 71 8702 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FLYNN, BERNARD J.		2. DATE AND HOUR OF DEATH 9/15/71 1:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1201			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3513 NEWLAND Rd. 21218			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-88	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days 7 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BERNARD FLYNN		14. MOTHER'S MAIDEN NAME MARY ANN McGANN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-38-3285		17. INFORMANT MRS. TERESA B. FLYNN (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH Bronchopneumonia Cardiac respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD & Cerebral Infarction Cerebrovascular Accident		11 days	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Parkinsonianism		Yes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Basal Skull Fracture			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) HOME	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) 2115 Southland Rd, Balt. Md.		21D. TIME OF INJURY (APPROX.) 9/4/71 7:30 PM		21E. HOW DID INJURY OCCUR A Fall down on the PATIO	
21F. HOW DID INJURY OCCUR A Fall down on the PATIO		22. I certify that (I) (this hospital) attended the deceased from 9/4/71 19 to 9/15/71 19		and that (I) (we) last saw the deceased alive on 12-25-9/15/71 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE S. Rafati		23B. DATE SIGNED 9/15/71		23C. PHYSICIAN'S NAME (Type) Salah Rafati MD	
23D. ADDRESS UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-71	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971	
25B. NAME OF REGISTRAR Robert E. J. [unclear]		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

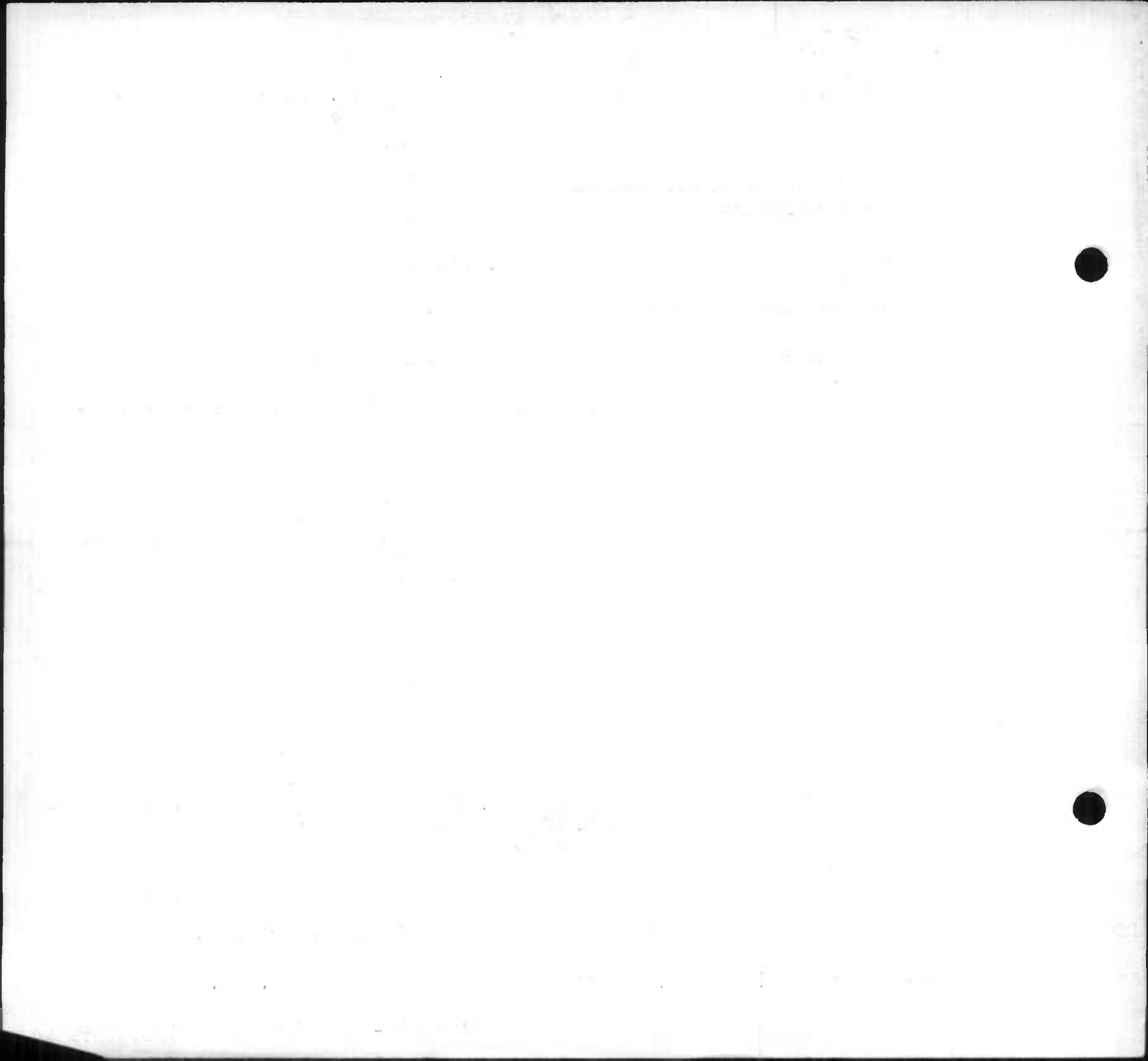
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8703	
BIRTH NO. G-420 71 8703		2. DATE AND HOUR OF DEATH 9/12/71 10:20 P.M.	
1. NAME OF DECEASED (Type or Print) Francis W. Gillis		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 349 Homeland Southway		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1898 9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Doctor		10B. KIND OF BUSINESS OR INDUSTRY Medicine	
11. BIRTHPLACE (State or foreign country) Carbondale, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander F. Gillis		14. MOTHER'S MAIDEN NAME Anna Boyle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220 44 2454	
17. INFORMANT Eileen W. Gillis		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 3 yrs. 2 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral Vascular Sclerosis			
19A. DATE OF OPERATION 9/12/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10/71 to 9/12/71 and that (I) (we) last saw the deceased alive on 9/10/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Earl L. Chambers, Jr.		23B. DATE SIGNED 9/13/71	
23C. PHYSICIAN'S NAME (Type) Earl L. Chambers, Jr.		23D. ADDRESS 100-W. Cold Spring Ln. Balto - Ind	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/15/71	
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld		ADDRESS Home 6500 York Rd.	

349-50011001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

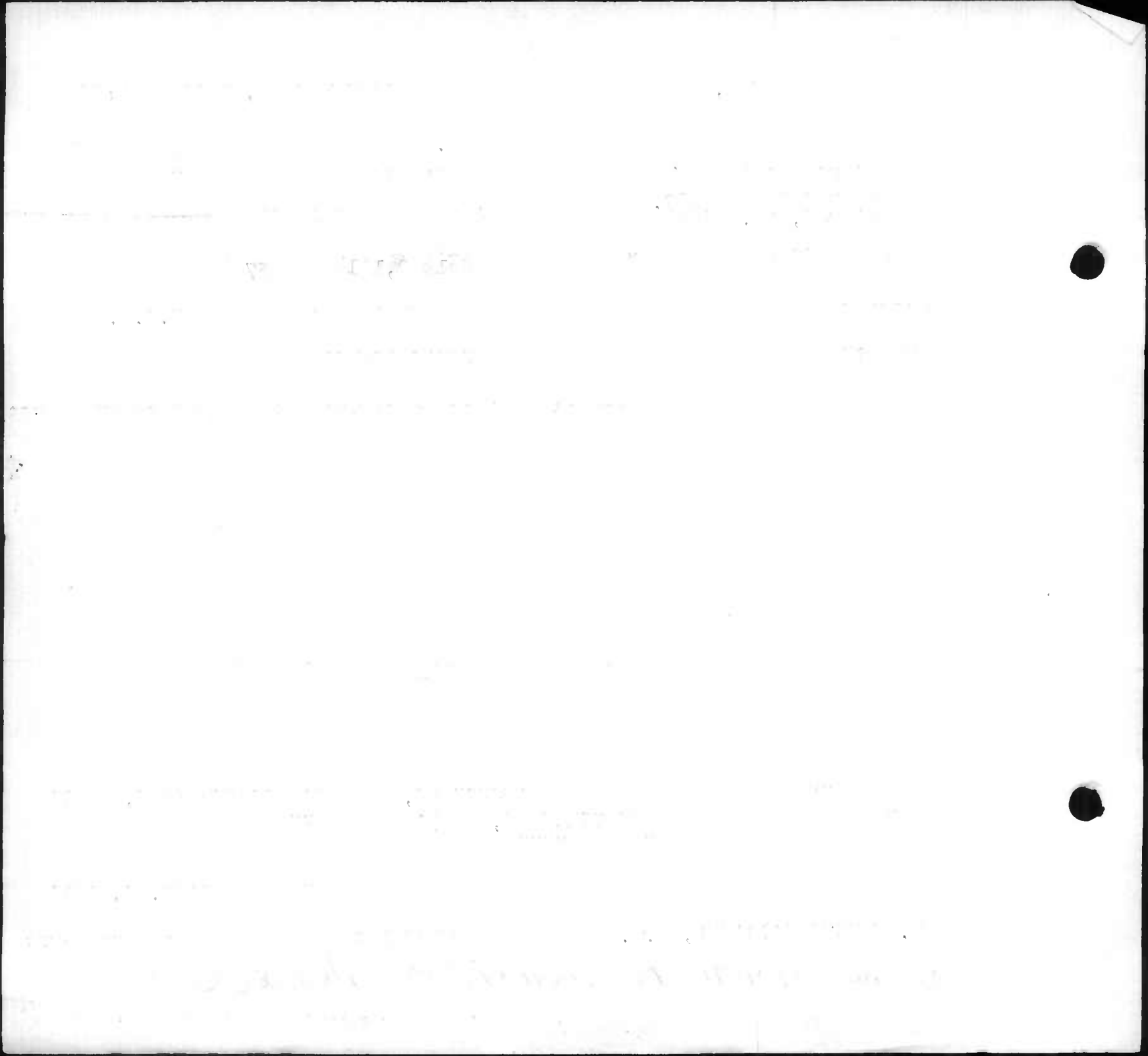
<p>T-520 71 8704</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8704</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Ferdinand Thomas</p>		<p>2. DATE AND HOUR OF DEATH Sept. 13, 1971 3:16 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO.</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 8206 Yarborough Road</p>	
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 9/21/09</p>
<p>9. AGE (in years last birthday) 61</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President</p>	<p>11. BIRTHPLACE (State or foreign country) Md.</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME Harry Thomas</p>	
<p>14. MOTHER'S MAIDEN NAME Anna Peterson</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>	
<p>16. SOCIAL SECURITY NO. 212-03-1557</p>		<p>17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.</p>	
<p>18. 25891</p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: CNS involvement by malignant carcinoid. and</p> <p>(B) Acute bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Malignant Carcinoid</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal Recent 3 years (1968)</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Invol medical examiner <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I)(this hospital) attended the deceased from Aug. 26 19 71 to Sept. 13 19 71 that (I)(we) last saw the deceased alive on Sept. 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Robert R. Wright, MD</p>		<p>23B. DATE SIGNED 9/13/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Robert R. Wright, SA Surg (R)</p>		<p>23D. ADDRESS US PHS Hospital, Balto, Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) cremation</p>		<p>24B. DATE 9/13/71</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory</p>		<p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 16 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Jansen, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home</p>		<p>25D. ADDRESS 6500 York</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)		BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
DUNN, HAZEL R		500 71 8705		71 8705		71 8705	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				SEPTEMBER 5, 1971 7:05P			
				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2037			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1914 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME JOHN BUNN				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212 34 1364		17. INFORMANT 4 ST AGNES RECORDS WILKENS & CATON AVES	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (CVA) (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension. (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 25, 19 71 to SEPTEMBER 5, 19 71 that (X) (we) lost saw the deceased alive on SEPTEMBER 5, 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE M. Yousuf Siddiqui				23B. DATE SIGNED SEPT. 5, 1971		23C. PHYSICIAN'S NAME (Type) M. YOUSUF SIDDQUI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 9-9-71		24C. NAME OF CEMETERY OR CREMATORY Mt. CALVARY CEM	
24D. LOCATION (City, town, or county) (State) ARUNDEL Co., Md				25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971			
25B. NAME OF REGISTRAR R. E. Farber, M.D.				25C. FUNERAL DIRECTOR A. BROWN 123 W MONTGOMERY ST			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8706	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>P-626</u>		71 8706			
1. NAME OF DECEASED (Type or Print) <u>FREDERICK C. PARKER (MSG)</u>			2. DATE AND HOUR OF DEATH <u>13 Sep 71</u> <u>1032</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U.S. Army Health Clinic Ft Holabird, Md. 21219</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BEQ</u> B. COUNTY <u>135, Rm 2, Ft Holabird, Md. 21219</u>		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2656</u>		
5. SEX <u>Male</u>	6. RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 June 1922</u>	9. AGE (In years last birthday) <u>48</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MSG, US Army</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	11. BIRTHPLACE (State or foreign country) <u>Natchez, Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Robert E Parker</u>			14. MOTHER'S MAIDEN NAME <u>Arlone Lessing</u>		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1944 to present</u>		16. SOCIAL SECURITY NO. <u>427-12-3289</u>	17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>E9051X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>GSW - entrance wound - immediate</u> DUE TO, OR AS A CONSEQUENCE OF: <u>palate</u> <u>were it wound seen</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>26-56</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>wound</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (If yes or No) <u>7</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		<u>26-56</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Ft. Holabird-Balto Bldg 135 Room 2</u>	
21D. TIME OF INJURY (APPROX.) <u>Sept 13, 1971 10:32 AM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Possibly self-inflicted.</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12 July 1971</u> to <u>13 Sep 1971</u> and that (I) (we) lost saw the deceased alive on <u>15 July 1971</u> and that (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Stuart Winakur, M.D.</u>			23B. DATE SIGNED <u>13 Sep 71</u>		
23C. PHYSICIAN'S NAME (Type) <u>STUART WINAKUR, CPT, MC</u>			23D. ADDRESS <u>US Army Health Clinic Ft Holabird, Md. 21219</u>		
24A. BURIAL CREMATION, DATE REMOVAL (Specify) <u>Burial</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Natchez Nat'l Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Natchez (Adams Co.) Miss.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Parker, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard County Funeral Home Ellicott City Maryland 21043</u>	

1914
The following is a list of the names of the persons who have been elected to the office of the President of the United States since the year 1789.

George Washington

John Adams

Thomas Jefferson

James Madison

James Monroe

James B. Monroe

James K. Polk

Franklin Pierce

Abraham Lincoln

Andrew Johnson

Ulysses S. Grant

Rutherford B. Hayes

James A. Garfield

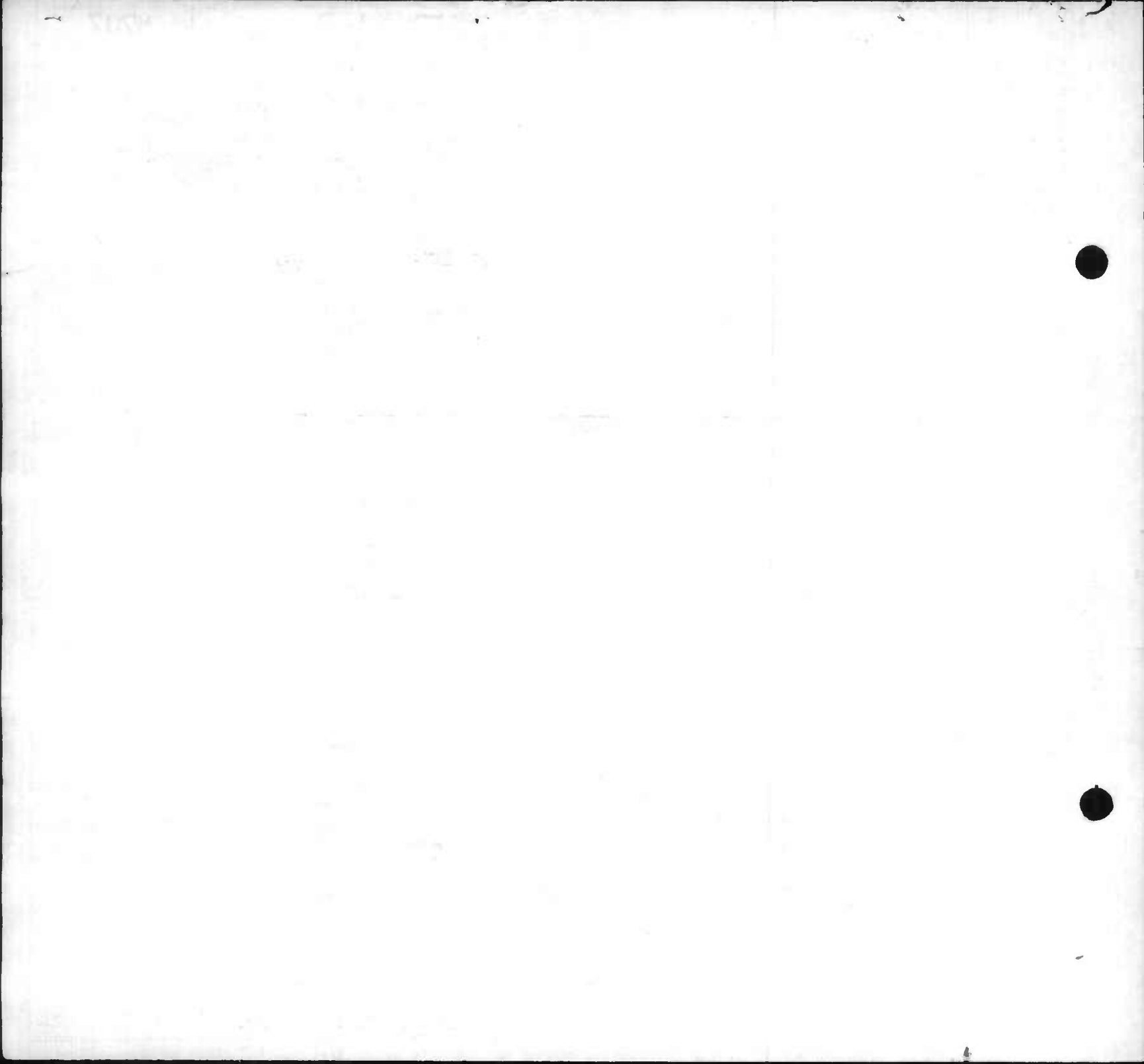
Benjamin Harrison

William McKinley

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8707	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. R-340		71 8707			
1. NAME OF DECEASED (Type or Print) RIDLEY, MRS. EVA			2. DATE AND HOUR OF DEATH 9-8-71 4:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission) A. STATE MARYLAND B. COUNTY 301		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 212 MASON ST.		
5. SEX F	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-26	9. AGE (In years last birthday) 44	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) N. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward Vines			14. MOTHER'S MAIDEN NAME Cora Maryland		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Coretta Ridley 1032 N. Washington St.	
18. 303.217-2500		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: severe electrolyte imbalance, diabetic coma		days	
		(B) DUE TO, OR AS A CONSEQUENCE OF: chron. + acute alcoholism		years/weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). hypertension, in terminal phase				days	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED S-		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 9-7-71 19 71 to 9-8 19 71 that (I) (we) last saw the deceased alive on 9-8 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard S. Alderman			23B. DATE SIGNED 9-8-71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 9-12-71	24C. NAME OF CEMETERY or CREMATORY Sharpsburg Cemetery		24D. LOCATION (City, town, or county) (State) Rockymount, N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR John E. Saylor		25C. FUNERAL DIRECTOR 1735 Harford Avenue Marshall W. Jones, Jr.	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EDWARD HUGHES				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 13 1971 12:20 P M.			
6. SEX male				7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. AGE (in years last birthday) 51				11. BIRTHPLACE (State or foreign country) Balto. Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward Hughes			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk				14B. KIND OF BUSINESS OR INDUSTRY Balto. Co. Bd. of Ed.			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes				17. SOCIAL SECURITY NO. 215-01-0385		18. INFORMANT Doris E. Hughes-8402 Nunley Drive	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Injuries				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 9-16-71				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway			
22D. TIME OF INJURY (APPROX.) 9-12-71 3:45 pm.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) State Rt. 100, 1/4 mi. east of Oakwood Rd.				22F. HOW DID INJURY OCCUR? Driver of auto that went out of control and overturned.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.				DATE SIGNED 9/13/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR Russell S. Fisher, M.D.		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.		ADDRESS -21206	

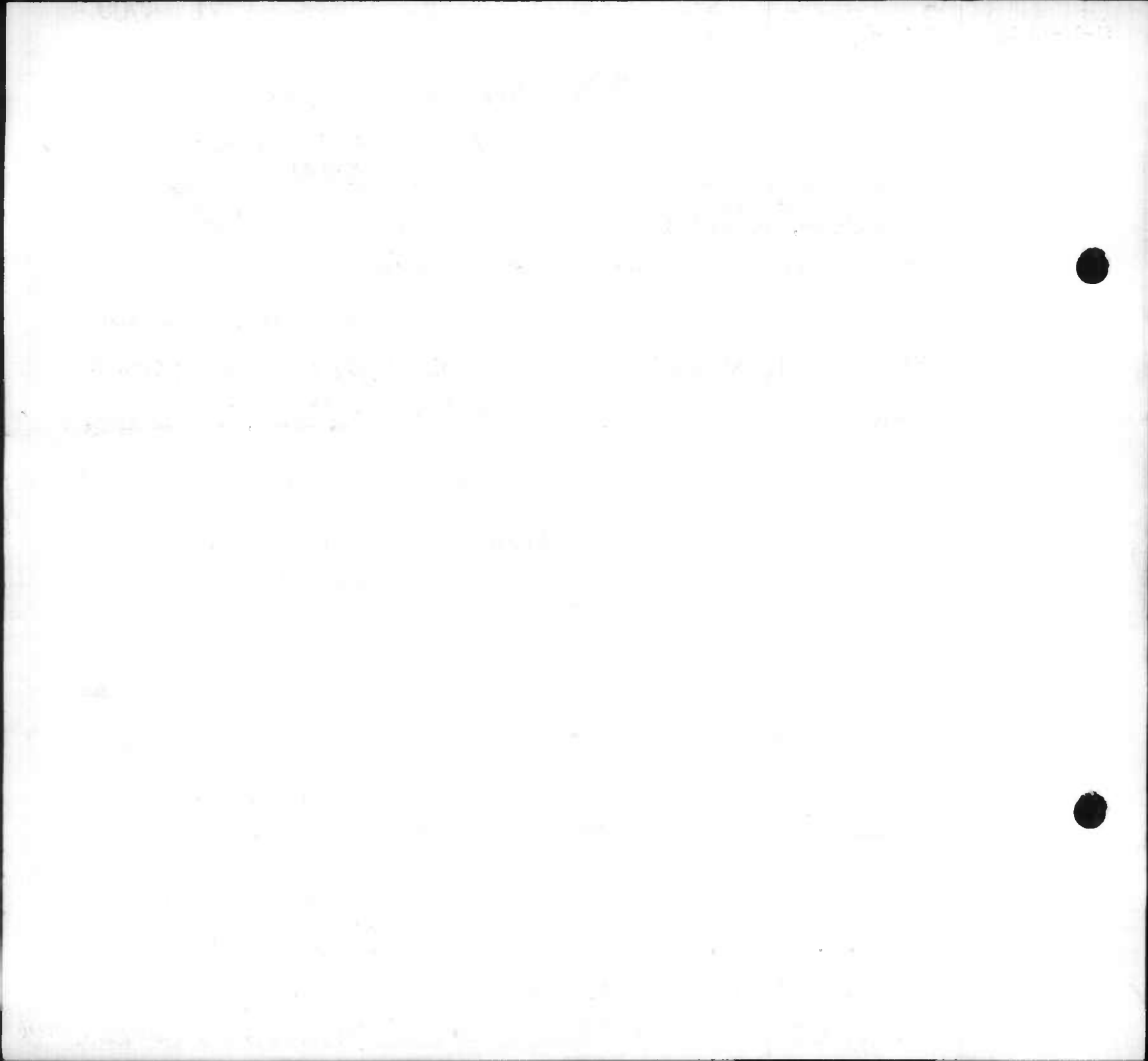
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A. C. ANDERSON & SONS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-636 71 8709		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8709	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth H. Fredariol</i>		2. DATE AND HOUR OF DEATH <i>9/13/71 1630 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>MARYLAND</i>		C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hosp</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		E. STREET AND NUMBER <i>121 Eastern Blvd</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8/2/23</i>	9. AGE (In years last birthday) <i>48</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary?</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U.S.A. MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>HENRY J. HORN</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET MASSONG</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WIK</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH RECORDS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>	
18. <i>422.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Prob. cardiac arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Etc?</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Sept 11</i> 19 <i>71</i> to <i>9/13/71</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Sept 13</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>P. Kurzweil</i>		23B. DATE SIGNED <i>9/13/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. P. Kurzweil, MD</i>	
23D. ADDRESS <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/17/71</i>	
24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1971</i>	
25B. NAME OF REGISTRAR <i>Ed E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Emellyn 306 MacO</i>		25D. ADDRESS	



H-635

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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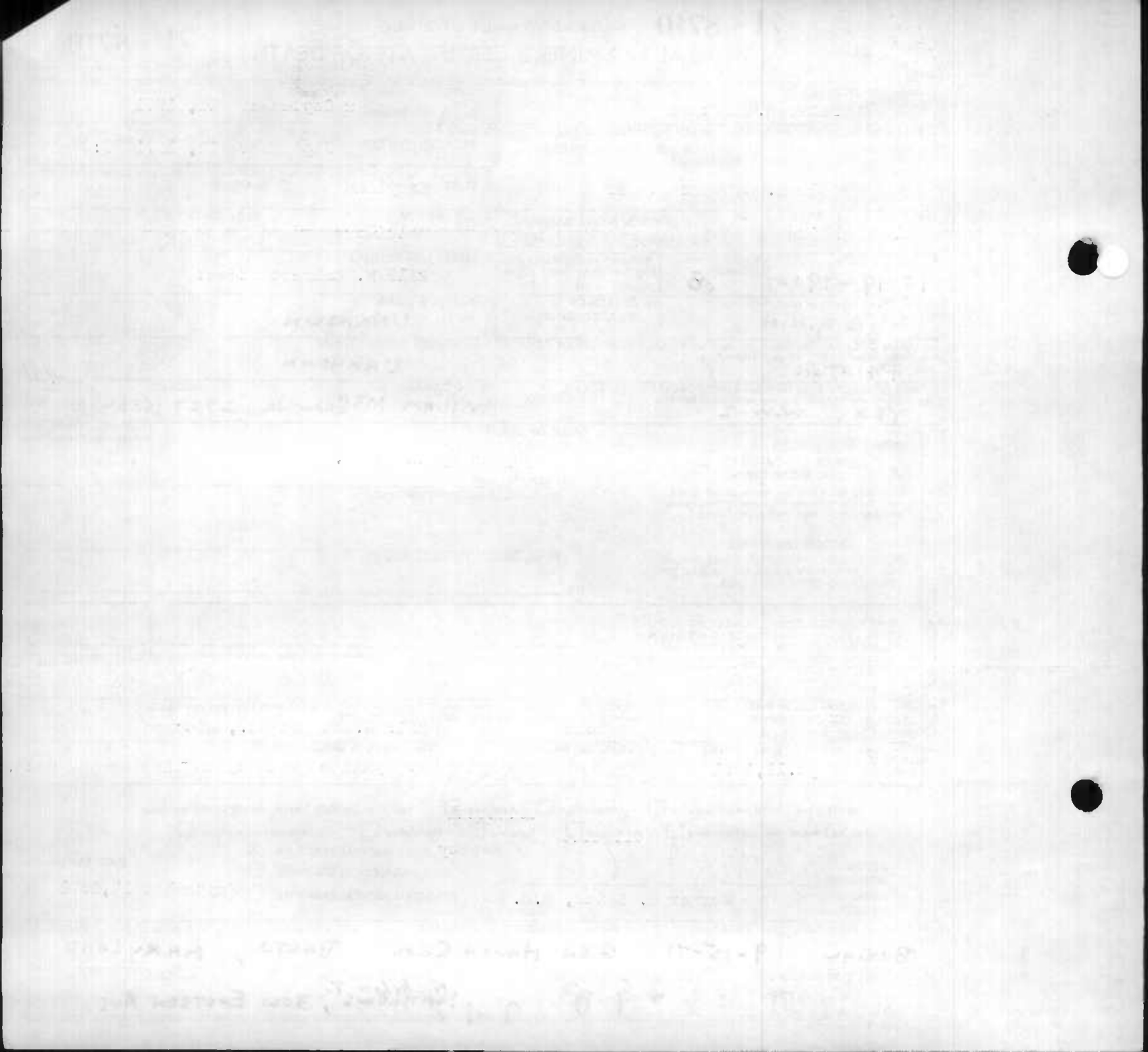
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REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Peter E. Hartman		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 11, 1971 Hour ? M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2519 N. Calvert Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 12, 1971 7:48 AM M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-19-1902		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 88		E. STREET AND NUMBER 2519 N. Calvert Street	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS William McGraw Jr. 2927 Keswick Rd. #11	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia by ligature. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2519 N. Calvert St., kitchen 1203		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Sept. 11, 1971 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? asphyxiated with cloth line around neck.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 12, 1971 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-71	
24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Nicholas Matthews		ADDRESS 3021 EASTERN AVE.	

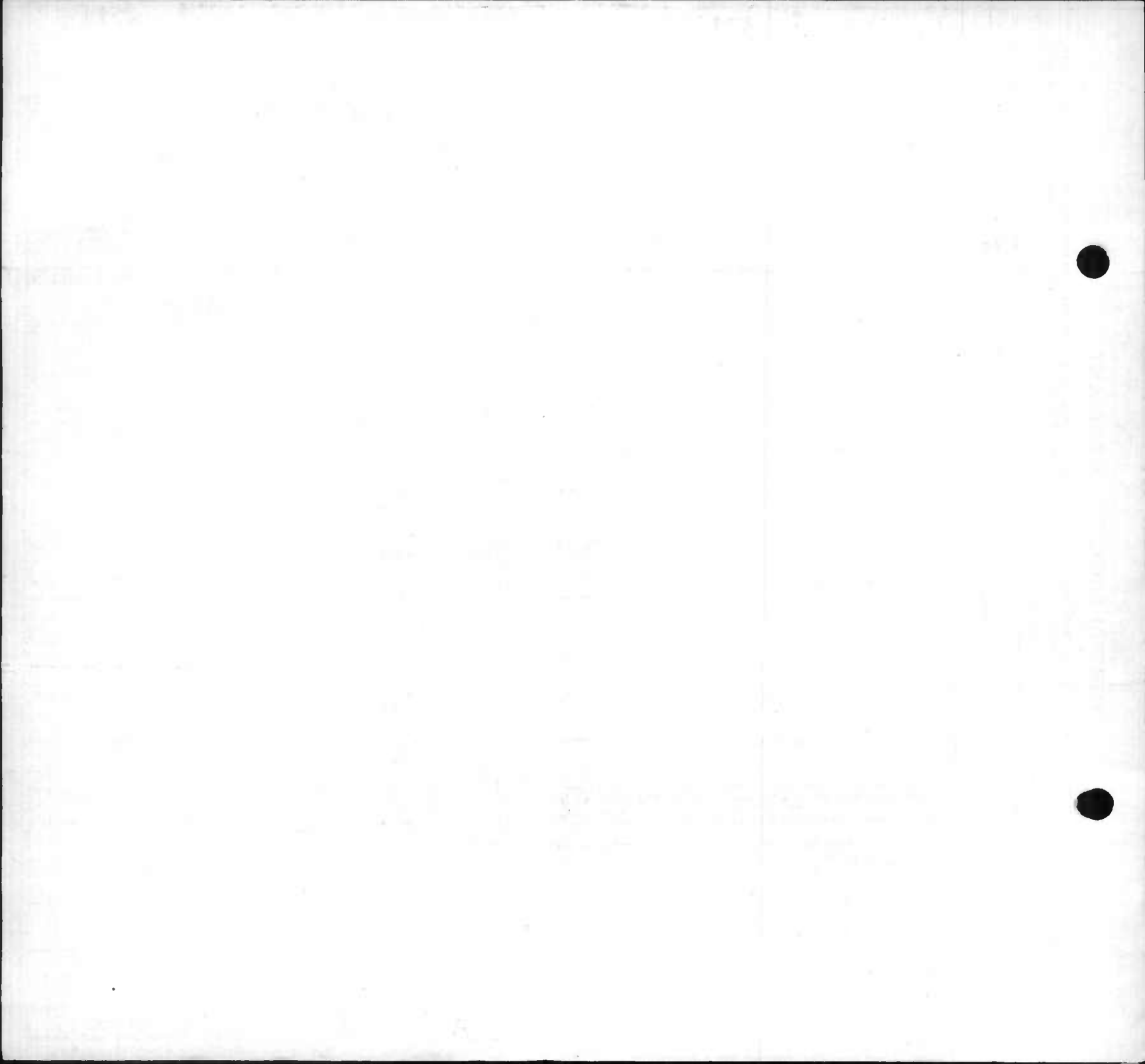
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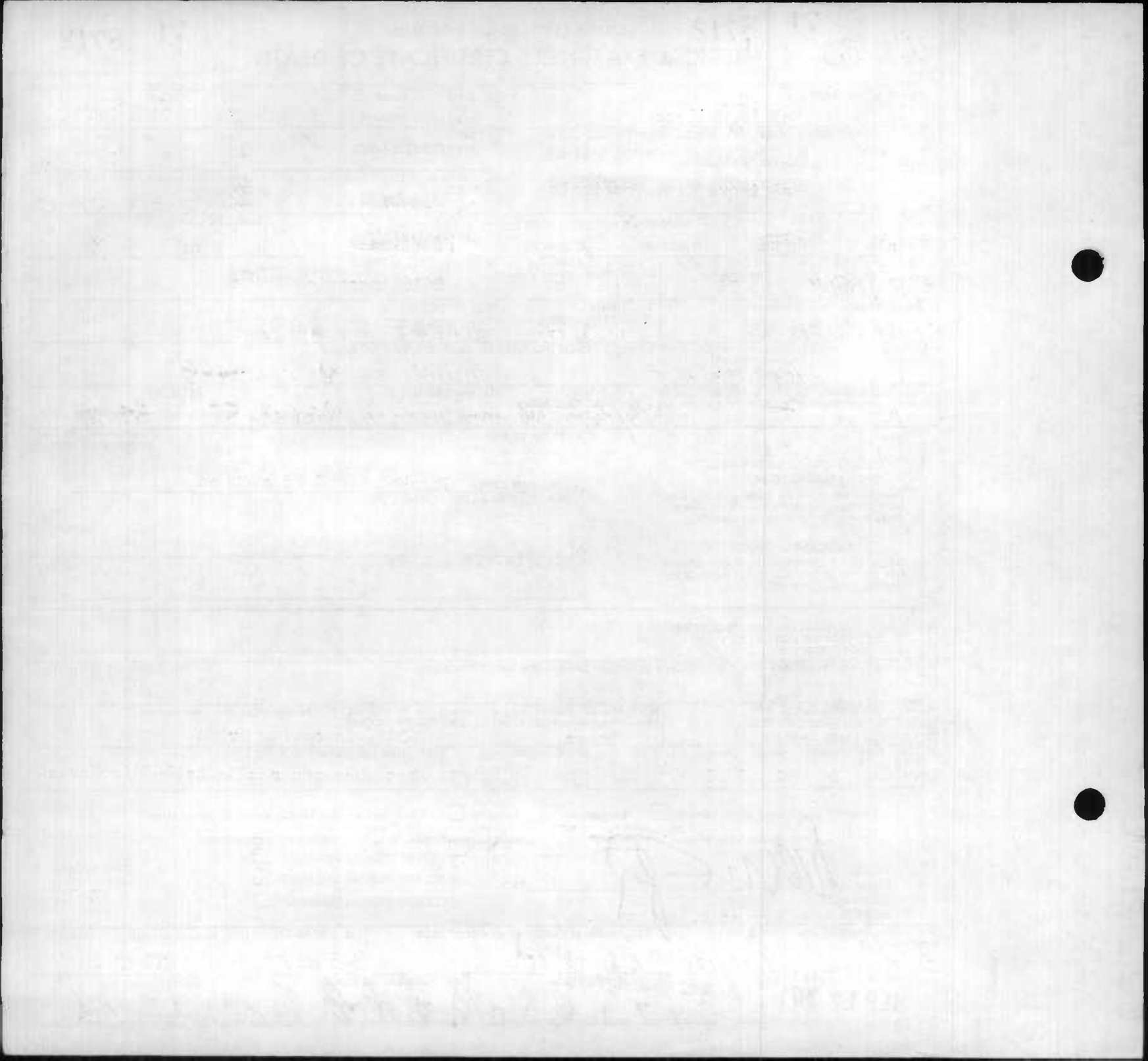
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-500 71 8711</u>				BALTIMORE CITY HEALTH DEPARTMENT		71 8711	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Helen A M. Han</u>				2. DATE AND HOUR OF DEATH <u>16-Sept-71 12⁰¹ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balt. General Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Md</u>		B. COUNTY <u>2544</u>	
5. SEX <u>F</u>				6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-30-12</u>				9. AGE (In years last birthday) <u>59</u>		10. Under 1 Yr. Months Days	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>J. Paul Kelly</u>	
14. MOTHER'S MAIDEN NAME <u>Lelia ?</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Thomas M. Han - Husband - Same</u>				18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4-12-21 + 250-9</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriolosclerotic Nephrosclerosis</u>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus</u>				(B) <u>Arteriosclerotic Cardiovascular Disease</u>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____			
22. DATE OF OPERATION <u>0</u>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No)		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED		31. HOW DID INJURY OCCUR?			
32. I certify that (1) (this hospital) attended the deceased from <u>9-9-71</u> to <u>16-Sept</u> 19 <u>71</u>		33. that (1) (we) last saw the deceased alive on <u>15-Sept</u> 19 <u>71</u>		34. and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
35. SIGNATURE <u>Richard E. Fisher MD</u>				36. DATE SIGNED <u>16-Sept-71</u>			
37. PHYSICIAN'S NAME (Type) <u>Richard E. Fisher MD</u>				38. ADDRESS <u>South Balt. Gen. Hospital</u>			
39. BURIAL CREMATION, REMOVAL (Specify) <u>urial</u>		40. DATE <u>9/20/71</u>		41. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		42. LOCATION (City, town, or county) (State) <u>Rithie Hwy Brooklyn Md. 21225</u>	
43. DATE REC'D BY HEALTH DEPT.		44. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		45. FUNERAL DIRECTOR <u>McGuffey Funeral Home</u>		46. ADDRESS <u>237 Patapsco Ave 25</u>	



BIRTH NO.		71 8712		BALTIMORE CITY HEALTH DEPARTMENT		71 8712	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) Nellie Willett				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 14 71 7:00 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 14 71 7:00 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE 21222				C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. SEX Female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3416 Loganview Drive 5300	
9. DATE OF BIRTH 8/10/1897		10. AGE (In years last birthday) 74		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT L. BRYAN				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			
15. MOTHER'S MAIDEN NAME MARY L. UPTEGROVE				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 218/38/3248				18. INFORMANT MARINUS A. WILLET, SR. - SAME			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) E922.19				CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. DATE OF OPERATION 0				21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3416 Loganview Drive 5300				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 9 12 71 3:00 A.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Shot when gun accidentally discharged			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED 9-14-71 EXAMINER'S NAME (Type)							
24A. BURIAL CREATION, REMOVAL (Specify) BURIAL		24B. DATE 9/18/1971		24C. NAME OF CEMETERY or CREATOR ELMWOOD		24D. LOCATION (City, town, or county) (State) GEORGETOWN, S. C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR Mr. Andrew Bradley, Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-652 71 8713		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8713	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Margaret E. Grannas				2. DATE AND HOUR OF DEATH 9-13-71 10:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Md. Gen. Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY - Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. Gen. Hosp.				C. CITY OR TOWN Balt.		D. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-16	
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - Miles Stiffler				14. MOTHER'S MAIDEN NAME - Marie Hall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 182-12-5334		17. INFORMANT Husband: 7 Quince Lane ADDRESS Richard J. Grannas Balto. Md. 21220	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Severe Congestive failure DUE TO, OR AS A CONSEQUENCE OF: (B) 3° Myocardial Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Old & New M.I.s.			
19A. DATE OF OPERATION 7-10-71				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Approx.) -				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 9-10-19 71 to 9-13-19 71 that (I) (we) last saw the deceased alive on 9-13-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Arnold G. Alexander MD				23B. DATE SIGNED SEP 17 1971		23C. PHYSICIAN'S NAME (Type) Arnold G. Alexander MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-16-71		24C. NAME of CEMETERY or CREMATORY Holly Hill Mem. Gardens	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971				25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda	
26A. ADDRESS 2922 Wise Ave. Dundalk, Md.				26B. ADDRESS 2922 Wise Ave. Dundalk, Md.			

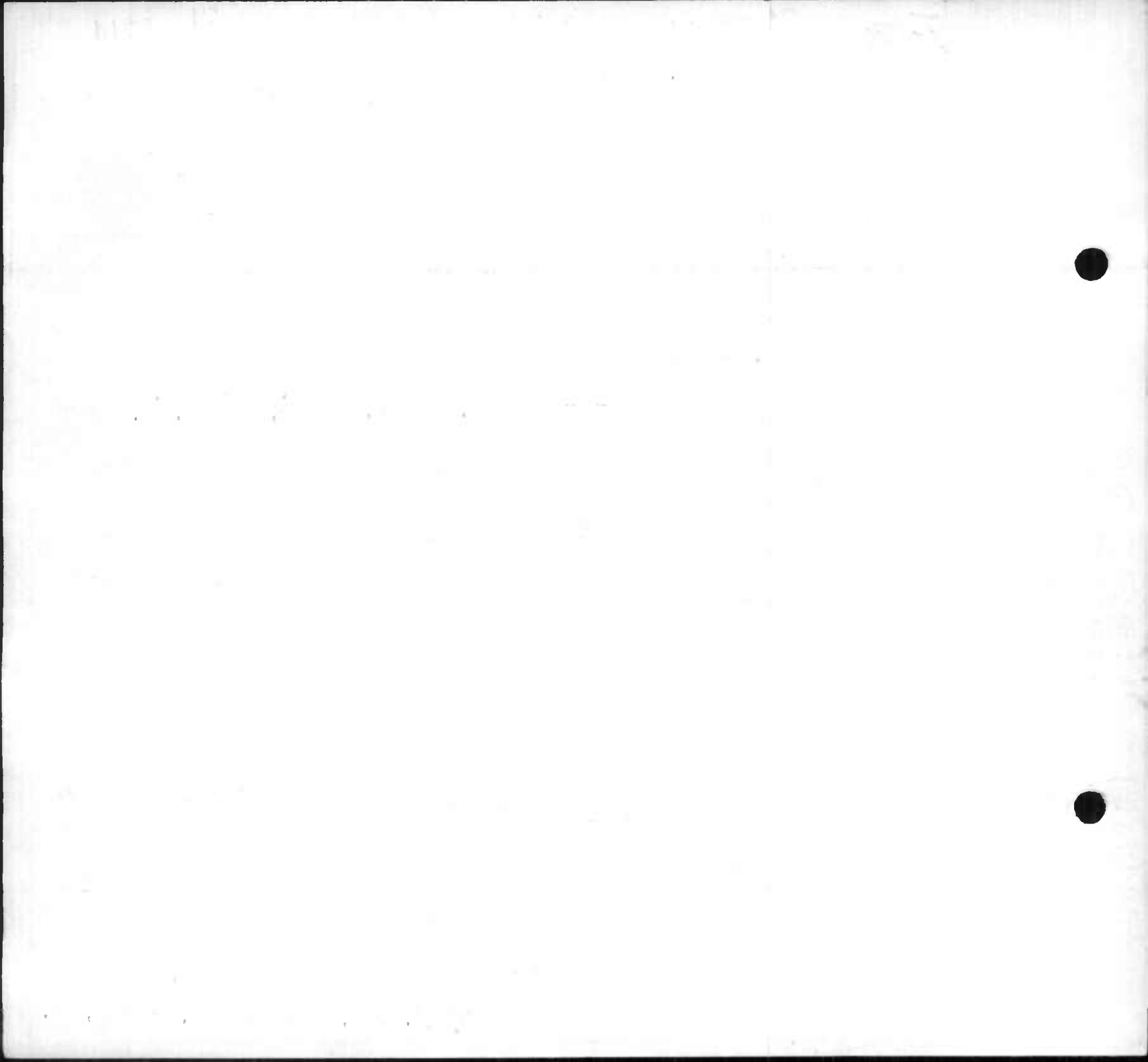
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8714</u>	
<div style="display: flex; justify-content: space-between;"> T-236 71 8714 BIRTH NO. </div>					
1. NAME OF DECEASED (Type or Print) <u>ARTHUR Tegeder</u>			2. DATE AND HOUR OF DEATH <u>9-12-71 8:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles Gen. Hosp.</u> <u>49 North Charles General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2610</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2 N. CLINTON St.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-01</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland USA</u>	
13. FATHER'S NAME <u>John F. Tegeder</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA Emmel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-1638</u>		17. INFORMANT (Wife) <u>2 N. Clinton St.</u> ADDRESS <u>Mrs. Sadie T. Tegeder, Balto. Md. 21224</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>Respiratory Failure</u> ACUTE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>SEVERE Chronic Obstructive Disease - yrs</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PULMONARY EMPHYSEMA & BRONCHITIS</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>PNEUMONIA -</u> RECENT					
19A. DATE OF OPERATION <u>9-11-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> 19 <u>71</u> to <u>9-12</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>9-12</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manankil</u>			23B. DATE SIGNED <u>9-12-71</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) <u>RUPERTO MANANKIL</u>			23D. ADDRESS <u>NORTH CHARLES GEN. HOSP. BALTO MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/16/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 12 1971</u>			
25B. NAME OF REGISTRAR <u>R. E. J. ...</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 8715	
X-616 BIRTH NO. 71 8715		71 8715				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KOERBER, ALMA E.				2. DATE AND HOUR OF DEATH 9/9/71 1005 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY Harford 6200 C. CITY OR TOWN Forest Hill D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 167 Rt. 3 Forest Hill			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-86		9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) N. Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Abraham				14. MOTHER'S MAIDEN NAME Not known			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service unknown		16. SOCIAL SECURITY NO. 25-3207-30		17. INFORMANT ADDRESS			
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). urinary infection				CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (B) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (C) hypertensive Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0—		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLINO <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-3-1971 to 9-9-1971 that (I) (we) last saw the deceased alive on 9-9-1971 and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE S. J. DESAI				23B. DATE SIGNED 9-9-71		23C. PHYSICIAN'S NAME (Type) S. J. DESAI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/12/71		24C. NAME of CEMETERY or CREMATORY St. Johns Blueheim		24D. LOCATION (City, town, or county) (State) Baltimore Co	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR W. Keelmann		ADDRESS Harford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

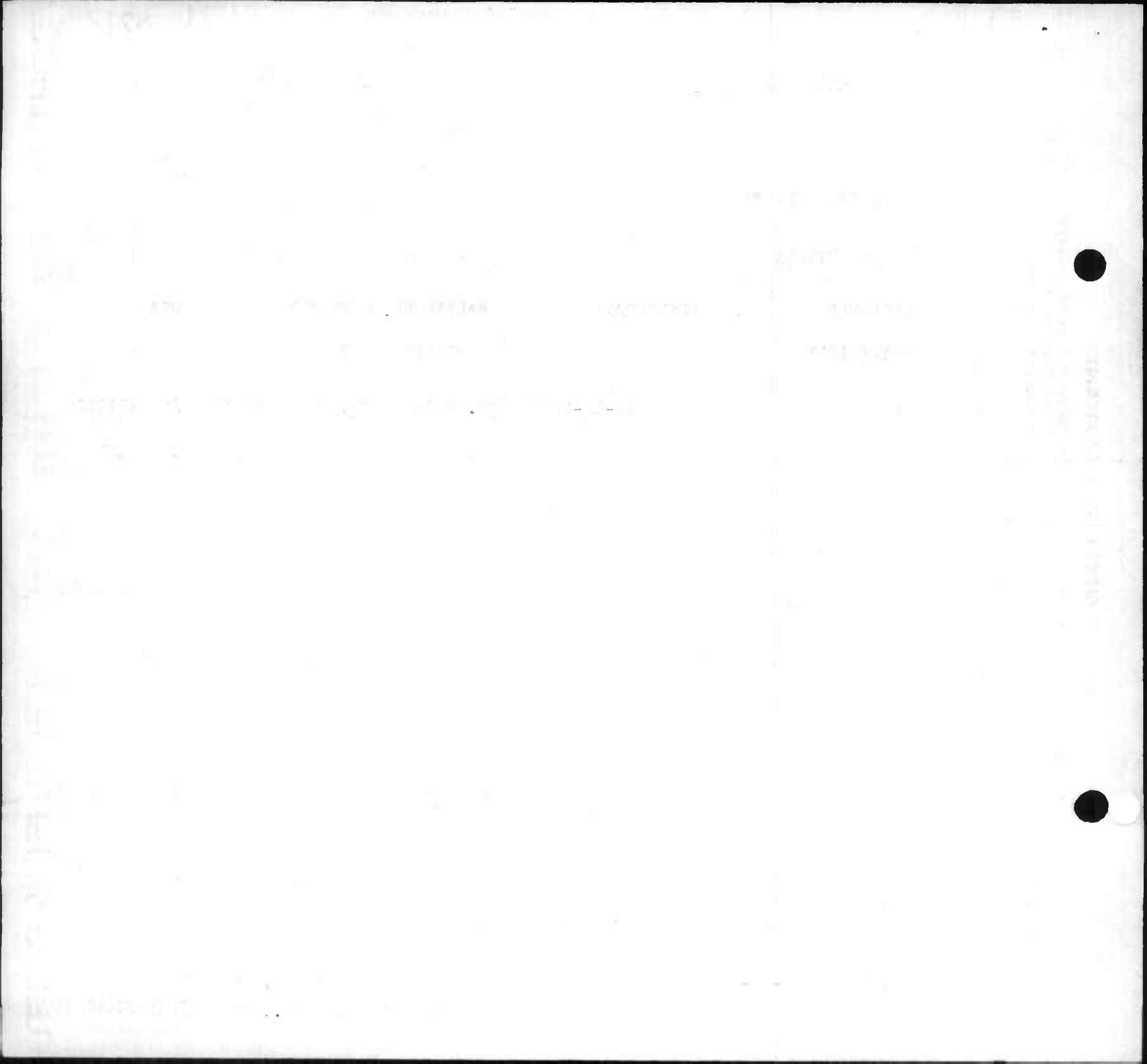
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8716	
CERTIFICATE OF DEATH					
BIRTH NO. K-656 71 8716		1. NAME OF DECEASED Samuel Kramer			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 Lincoln Hospital		2. DATE AND HOUR OF DEATH Sept 15/71 9:25 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Lincoln Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2719			
5. SEX Male 6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 18, 1901 9. AGE (in years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (State or foreign country) Lithuania	
13. FATHER'S NAME Meyer Kramer		14. MOTHER'S MAIDEN NAME Lena?			
15. Was Deceased Ever in U. S. Armed Forces? No		16. SOCIAL SECURITY NO. 212-09-1335		17. INFORMANT Mrs. Mildred Boyfel - 3202 old	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small>		(A) IMMEDIATE CAUSE Heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Heart block DUE TO, OR AS A CONSEQUENCE OF: (C) H.A.S.U.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 69 to Sept 15 19 71 that (I) (we) last saw the deceased alive on August 25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph C. Matchar M.D.		23B. DATE SIGNED 9/16/71		23C. PHYSICIAN'S NAME (Type) JOSEPH C. MATCHAR MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 16/71		24C. NAME of CEMETERY or CREMATORY Petach Tikvah Rcedale	
24D. LOCATION (City, town, or county) (State) Rcedale, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971			
25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR'S NAME Sol Sherman & Sons			
25D. ADDRESS 6110 Rostenbaum Park					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

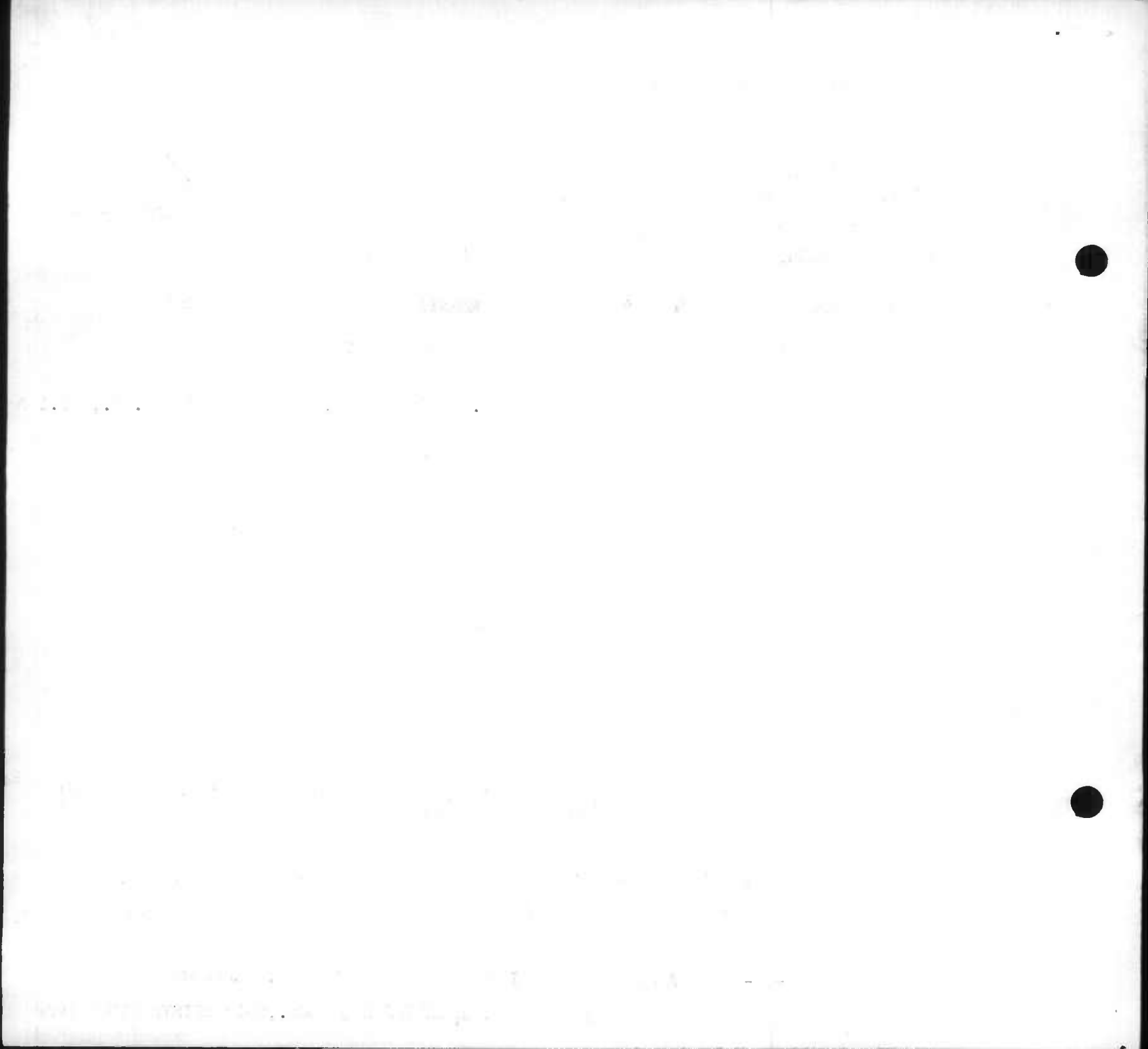
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8717	
CERTIFICATE OF DEATH					
BIRTH NO. L-100 71 8717					
1. NAME OF DECEASED (Type or Print) ISADORE XXXXXXXX (LEE) LEVY			2. DATE AND HOUR OF DEATH 9-14-71 3:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION!			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2730		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3206 BONNIE RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1912	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days if Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME MEYER LEVY			14. MOTHER'S MAIDEN NAME TILLIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-12-8985		17. INFORMANT ADDRESS MRS. GRACE LEVY, 3206 BONNIE ROAD #21215	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Acute MI DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-14 1971 to 9-14 1971 that (I) (we) last saw the deceased alive on 9-14 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Oroszlan DEGREE				23B. DATE SIGNED 9-14-71 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) PETER OROSZLAN MD DEGREE				23D. ADDRESS 1819 Rambling Ridge La #101 DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-71		24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		(State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR John E. Gable, 40.0 0 0		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

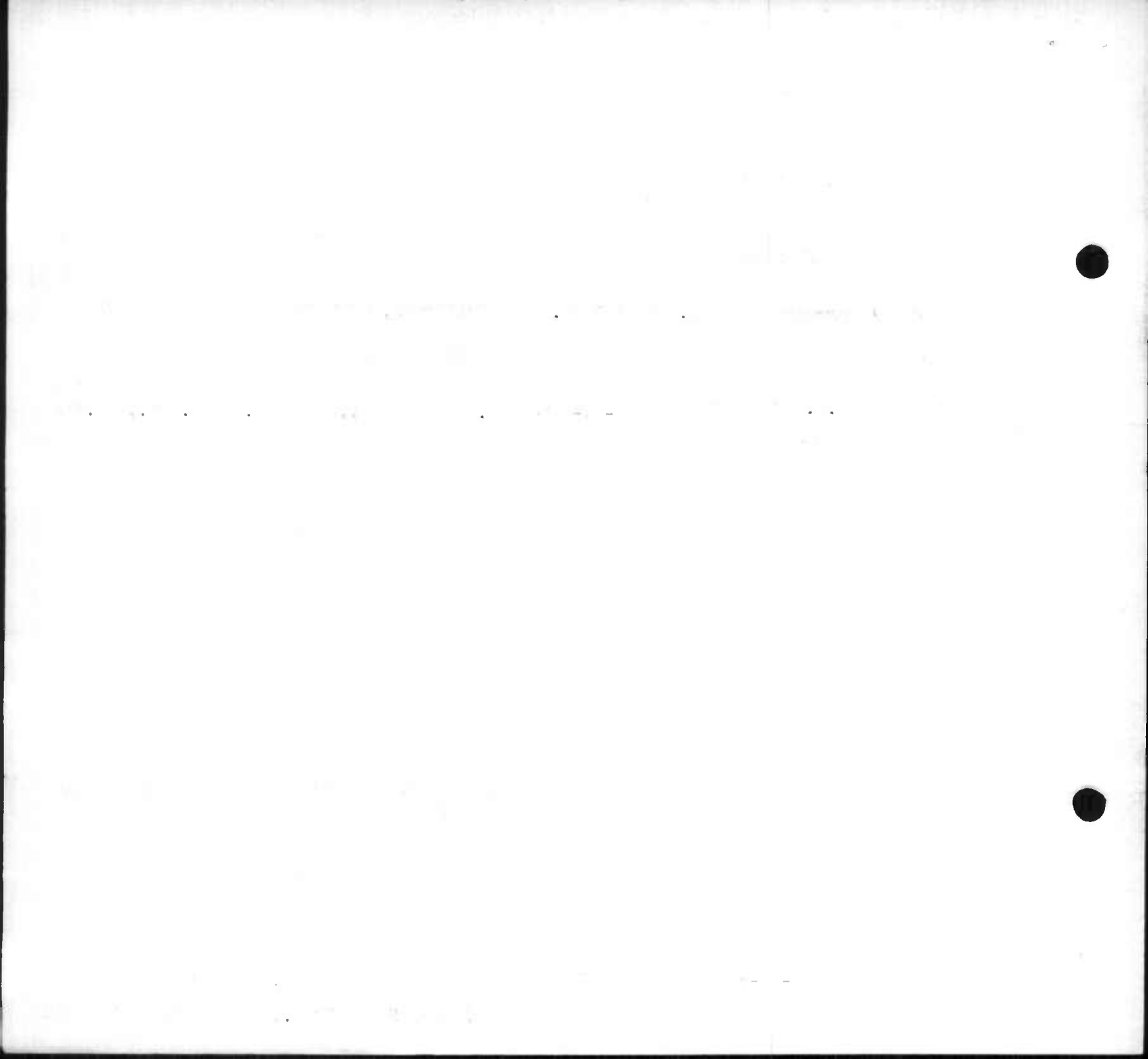
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-562 71 8718		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 8718
BIRTH NO.		1. NAME OF DECEASED (Type or Print) TAMRES, DORA		2. DATE AND HOUR OF DEATH Sept 14 1971 3:21 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC 12 BENEDICTE AVE AT GREENSPRING BALTO MD 21215		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15 - 00
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		9. AGE (In years last birthday) 70
13. FATHER'S NAME ABRAHAM KARSH		14. MOTHER'S MAIDEN NAME FAGA ?		11. BIRTHPLACE (State or foreign country) RUSSIA
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT MR. LOUIS TAMRES, 6962 MILBROOK PK. DR., APT. 1 A		ADDRESS		
18. 412.3 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASVHD.		(C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Sept. 13 19 71 to Sept 14 19 71 that (I) (we) lost saw the deceased alive on Sept 14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE C. Thananopavarn MD		23B. DATE SIGNED Sept. 14		23C. PHYSICIAN'S NAME (Type) CHALEMPHIL THANANOPAVARN
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-71		24C. NAME of CEMETERY or CREMATORY ANSHE EMUNAH (AITZ CHAIM)
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR James E. Taylor		25C. FUNERAL DIRECTOR SQU LEVINSON & BROS., 6010 REISTERSTOWN ROAD
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25D. ADDRESS		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

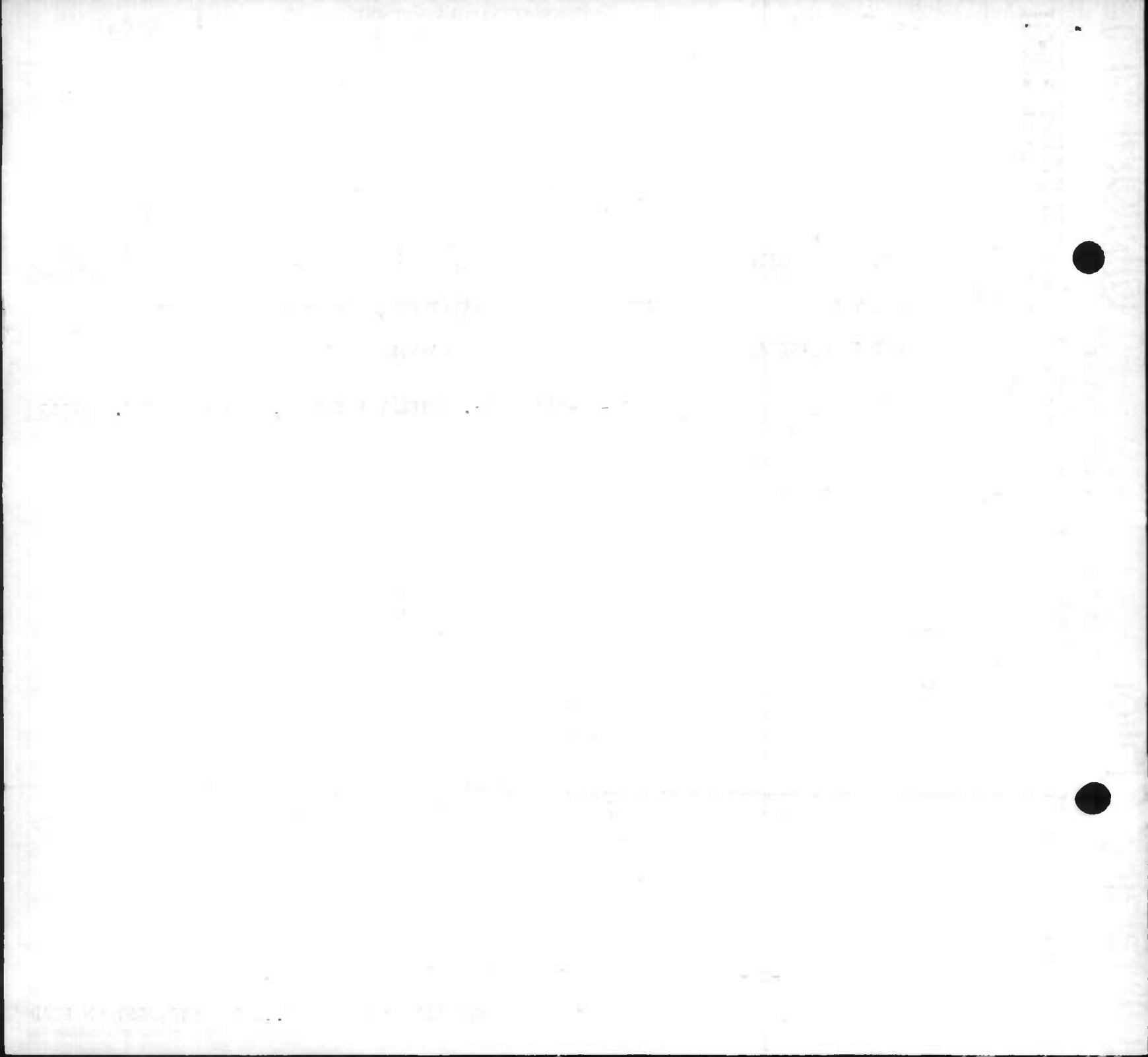
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8719</u>	
<div style="display: flex; justify-content: space-between;"> B-500 71 8719 </div>					
1. NAME OF DECEASED (Type or Print) <u>BAUM, KENNY</u>		2. DATE AND HOUR OF DEATH <u>September 13, 1971 4:40 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Singai Hospital of Baltimore Inc.</u> <u>Belvedere Aven. Greenspring</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>34 Wooded Way #08</u>			
5. SEX <u>Male</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1915</u>	9. AGE (In years last birthday) <u>56</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MD. CHICKEN CO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>SAMUEL BAUM</u>		14. MOTHER'S MAIDEN NAME <u>SARAH SIRKIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. II ARMY</u>		16. SOCIAL SECURITY NO. <u>216-01-6006</u>		17. INFORMANT ADDRESS <u>MR. NATHAN BAUM, 6210 PK. HIGHTS. AVE., APT. 703 321215</u>	
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>advanced carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 0.5; border-left: 1px solid black; padding-left: 5px;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>September 11, 1971</u> to <u>September 13, 1971</u> that (I) (we) last saw the deceased alive on <u>September 13, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Kalisky</u>		23B. DATE SIGNED <u>9/13/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR Z. KALISKY</u>		23D. ADDRESS <u>Singai Hospital of Baltimore Inc.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-15-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>SHAAREI ZION</u>	
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

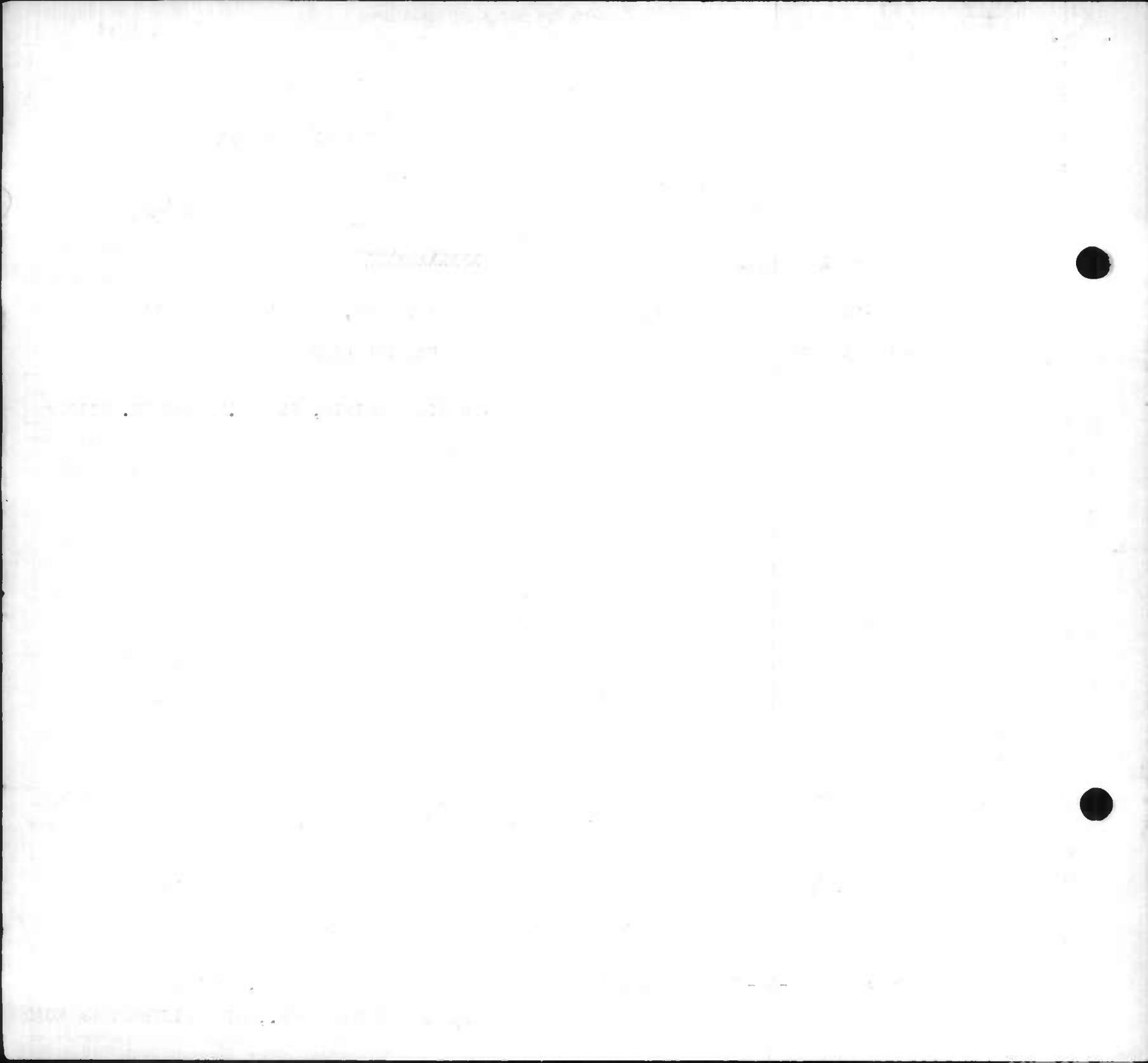
7-452 71 8720		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8720	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLIS FLINKMAN		2. DATE AND HOUR OF DEATH Sept 13, 1971 10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. OF BALTO.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2831		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/25/05		9. AGE (In years last birthday) 65		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME PHILIP FLINKMAN		14. MOTHER'S MAIDEN NAME FANNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-1528		17. INFORMANT ADDRESS MRS. SHIRLEY FLINKMAN, 5503 NOME AVE., #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MI Acute		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolism		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 8/27 19 71 to 9/13 19 71 that (he) (we) last saw the deceased alive on 9/13/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fortunato V. Elizaga		23B. DATE SIGNED 9/13/71		23C. PHYSICIAN'S NAME (Type) FORTUNATO V. ELIZAGA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-15-71		24C. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. SEP 17 1971		24F. NAME OF REGISTRAR 000	
25A. FUNERAL DIRECTOR ADDRESS SDL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25B. NAME OF REGISTRAR		25C. DATE OF REGISTRATION	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

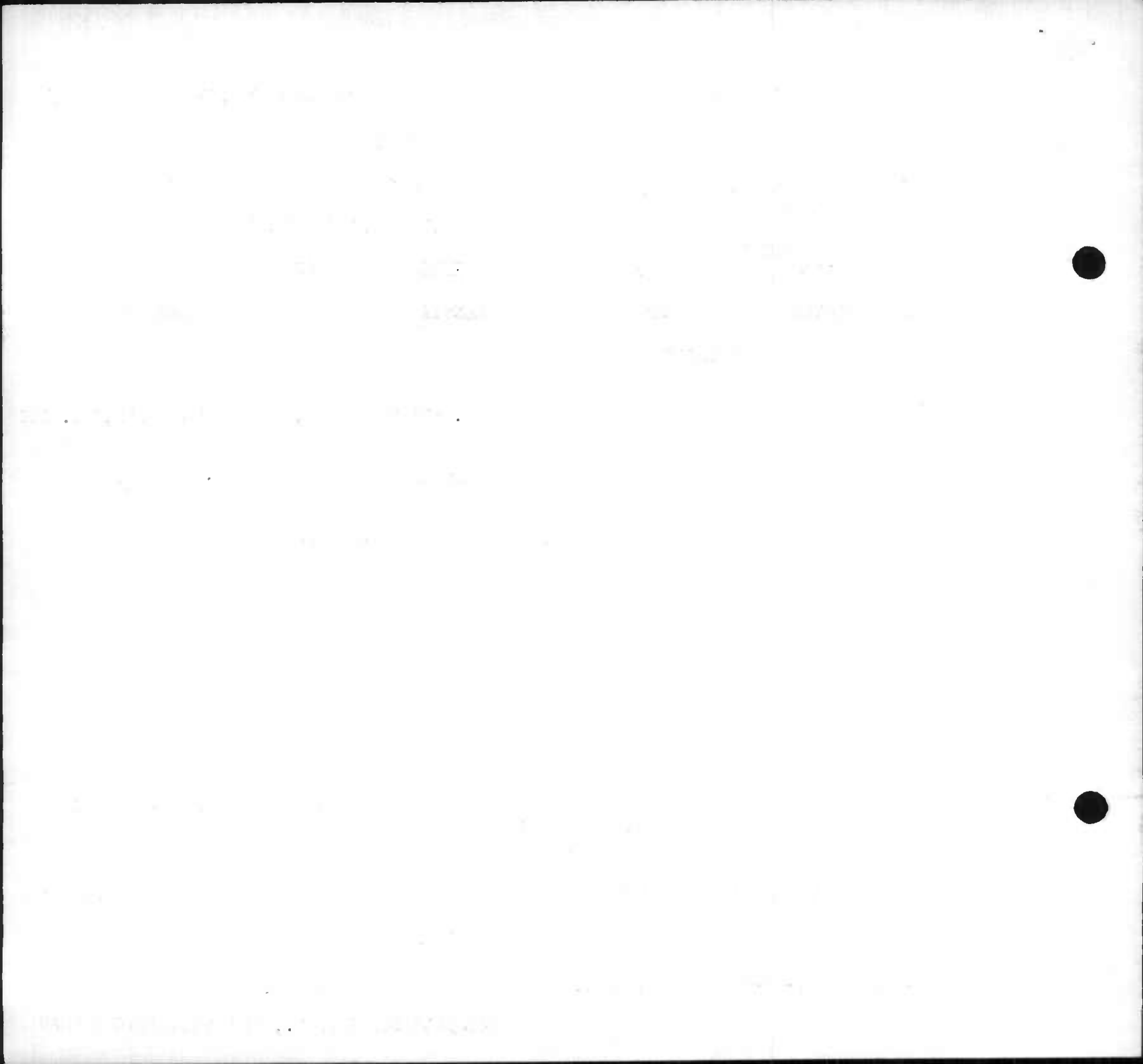
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 8721	
R-220 71 8721				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) HANNAH REISIG				2. DATE AND HOUR OF DEATH 9/12/71 11:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hosp. of Balt., Inc.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7107 PLYMOUTH ROAD			
5. SEX FEMALE	6. RACE W HITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/1908	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL	10B. KIND OF BUSINESS OR INDUSTRY RETAIL	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
13. FATHER'S NAME MEYER REISIG			12. CITIZEN OF WHAT COUNTRY? USA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MISS HILDA REISIG, 7107 PLYMOUTH RD. #21208		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERTENSION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from SEPT. 11 1971 to SEPT. 12 1971 that (H) (we) last saw the deceased alive on SEPT. 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jan Sunshine M.D.				23B. DATE SIGNED 9/12/71			
23C. PHYSICIAN'S NAME (Type) IAN SUNSHINE M.D.				23D. ADDRESS Sinai Hosp. of Balt., Inc., Balt., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-14-71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOLO LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

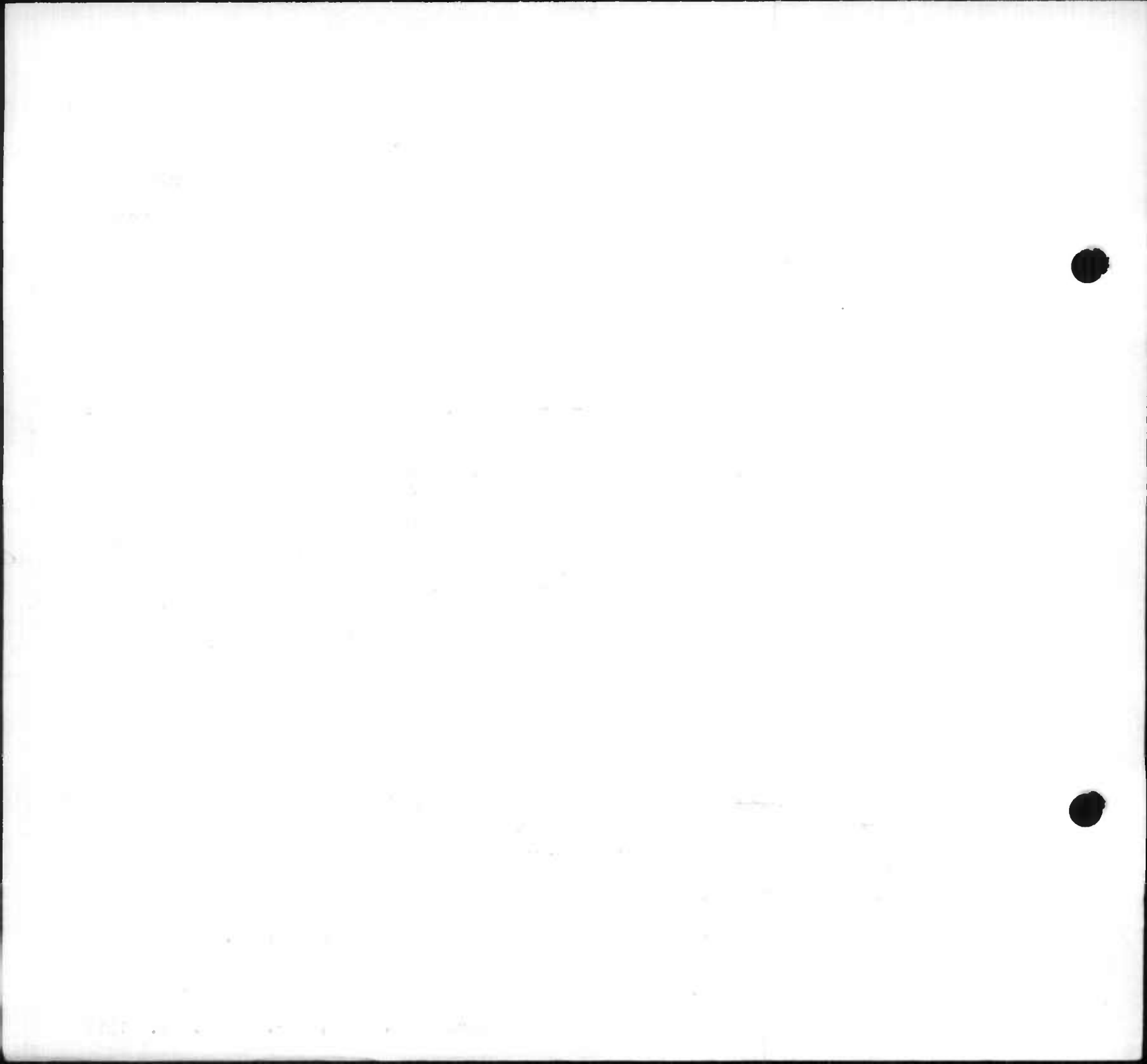
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8722</u>
BIRTH NO. <u>5-452 71 8722</u>				
1. NAME OF DECEASED (Type or Print) <u>HARRY GOLNICK</u>		2. DATE AND HOUR OF DEATH <u>September 13, 1971</u> <u>5:45 A/</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1513</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LEVINDALE HEBREW GERIATRIC CENTER</u> <u>AND HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2708 BOARMAN AVENUE</u>		
5. SEX <u>Male</u>	6. RACE <u>WHITE</u> <u>Human</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TAILOR</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>GOLNICK</u>		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. BETTY DRESSER, 3501 BEAGLE LANE, APT. 202</u>
18. <u>412-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary Congestion & edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		(If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>August 16</u> <u>1950</u> to <u>September 13</u> <u>1971</u> that <u>(H)</u> (we) last saw the deceased alive on <u>September 13</u> <u>1971</u> and that <u>(H)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (we) (did) <u>(H)</u> view the body after death.				
23A. SIGNATURE <u>Theodore R. Reiffe</u>		23B. DATE SIGNED <u>September 13, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>THEODORE R. REIFF, M.D.</u>
23D. ADDRESS <u>LEVINDALE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-14-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>
24D. LOCATION <u>BALTIMORE, MARYLAND</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME OF REGISTRAR <u>SOL LEVINSON</u>		25C. FUNERAL DIRECTOR <u>BROS., 6010 REISTERSTOWN ROAD</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

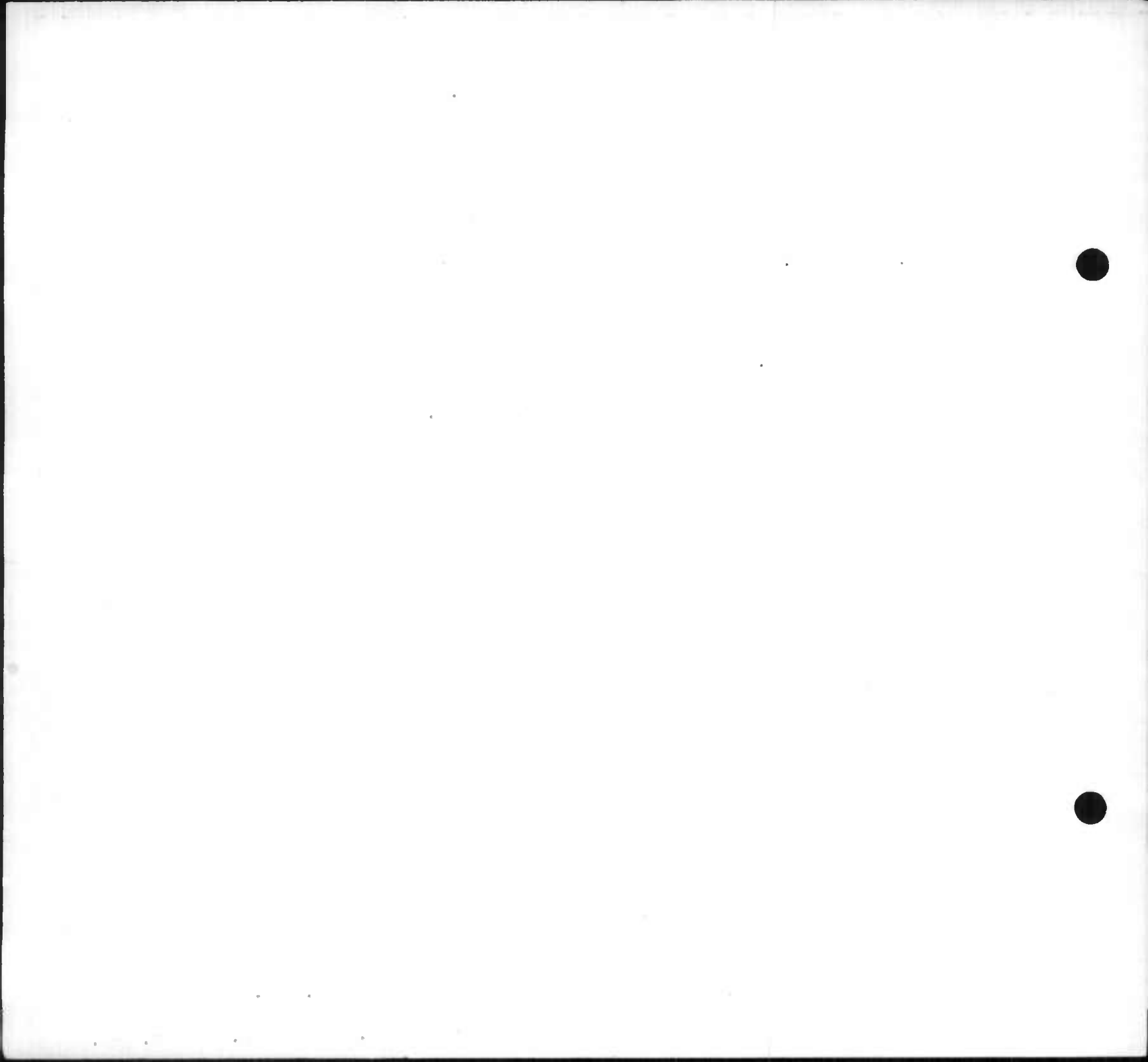
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8723</u>	
BIRTH NO. <u>M-200 71 8723</u>					
1. NAME OF DECEASED (Type or Print) <u>MAY Ada MASSEY</u>		2. DATE AND HOUR OF DEATH <u>9/15/71 1:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Gould Convalesarium</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2641</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5517 Todd Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1904</u>	9. AGE (In years last birthday) <u>67</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Renner</u>		14. MOTHER'S MAIDEN NAME <u>Ada Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>WD705-05-6065</u>		17. INFORMANT ADDRESS <u>Mrs. Myrtle Schwartz, 3315 Moravia Ave. #14</u>	
18. <u>4-3291</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Multiple Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
			(B) <u>Bacterial Artery Infection</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>months</u>
			(C) <u>Antisclerotic Embolic Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>year</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cow, Cystic Heart Disease, Compensated Pneumonia</u>					
19A. DATE OF OPERATION <u>9/18/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/11/71</u> to <u>9/15/71</u> that (I) (was) last saw the deceased alive on <u>9/11/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>9/15/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley MD</u>	
23D. ADDRESS <u>Baltimore, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/18/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

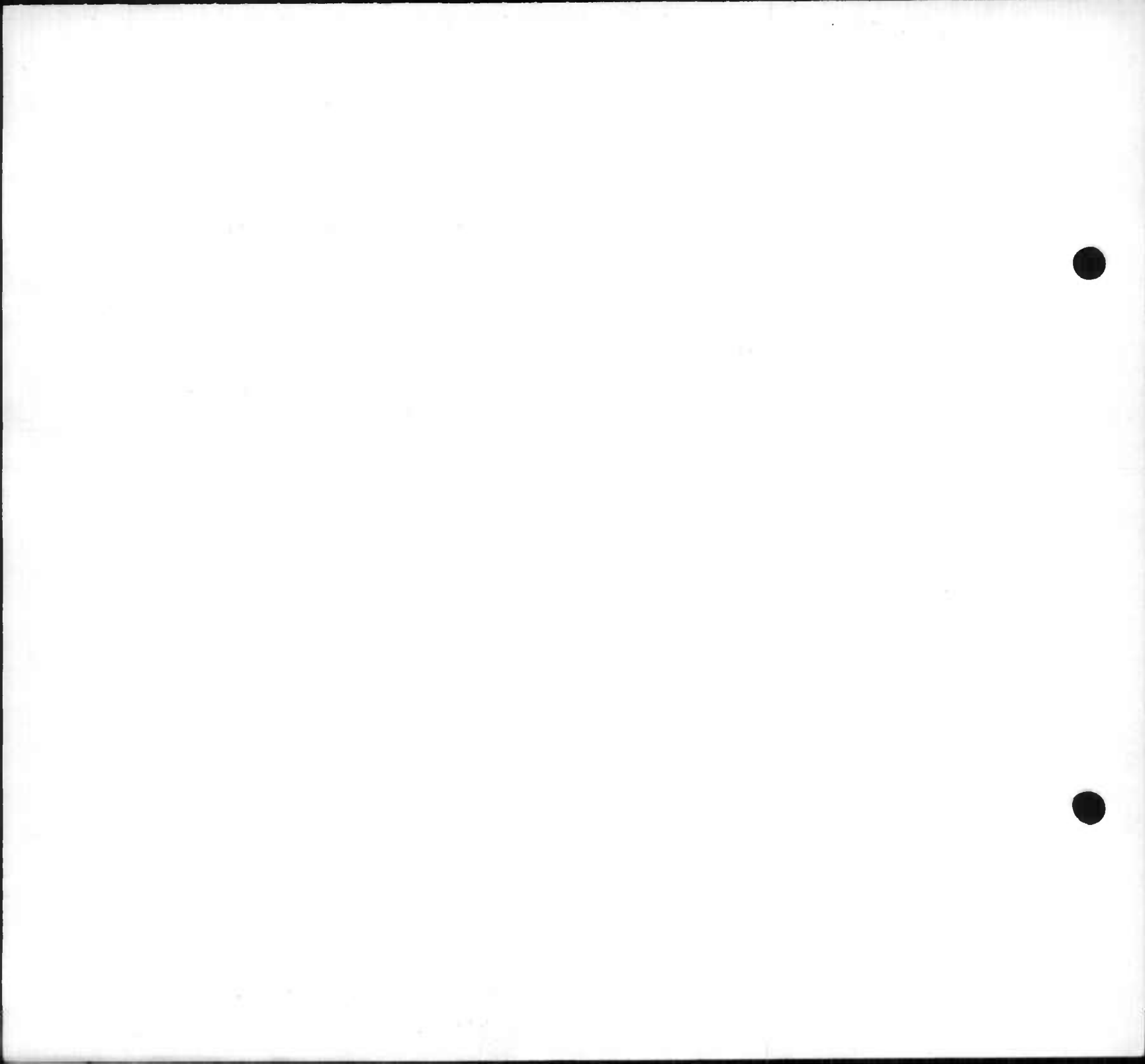
B-615 69 71 8724		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8724	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BRABHAM FRANCIS M.		9/14/71 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Maryland General Hosp.				Md. Baltimore city 2631	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
4201 Glenmore Ave.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
M.	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9.18.01	69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Contractor				Md.	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Thomas J. Brabham				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
no				216-18-6411	
17. INFORMANT				ADDRESS	
Mrs. Susie Brabham				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		Jan. 71 - Sept. 71	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Renal failure.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 Jan-71		Ca of stomach.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/11 1971 to 9/14 1971 that (I) (we) last saw the deceased alive on 9/14 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. GAKUBO				9-14-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
C. GAKUBO				Maryland General Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/18/71		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 17 1971		E. J. Ruck, M.D.		Leonard J. Ruck Inc. Balto. Md.	
24D. LOCATION (City, town, or county)				24E. STATE	
Balto. Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8725</u>	
<p><u>J-525 71 8725</u></p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Jenkins, Landora M.</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9/15/71 10:30 P.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hosp</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u></p> <p>C. CITY OR TOWN <u>Woodlawn</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>5929 Montgomery Avenue, 21207</u></p>			
<p>5. SEX <u>F</u></p>	<p>6. RACE <u>W</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>10/15/86</u> AGE (in years last birthday) <u>84</u></p> <p>If Under 1 Yr. Months: Days: Hours: Min.</p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Virginia</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>Compton</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>? unknown</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>5929 Montgomery Avenue</u> <u>Husband Penny Jenkins</u></p>			
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>(A) IMMEDIATE CAUSE <u>ASCVD and CHF</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> 19 <u>71</u> to <u>Sept 15</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 15 10:30 PM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Ann Tae Sung M.D.</u></p>		<p>23B. DATE SIGNED <u>Sept 15/71</u></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>TAE, S. AHN, M.D.</u></p>		<p>23D. ADDRESS <u>BON SECOURS HOSP BALT. Md.</u></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>9/18/71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u></p>			
<p>25B. NAME OF REGISTRAR <u>Wituzke, 1630 Edmondson avenue, 21228</u></p>		<p>25C. FUNERAL DIRECTOR <u>Wituzke, 1630 Edmondson avenue, 21228</u></p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-355 71 8726 **BALTIMORE CITY HEALTH DEPARTMENT** **CERTIFICATE OF DEATH** **X** **REG. NO. 71 8726**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) *Pittman Alice*

2. DATE AND HOUR OF DEATH
9-10-71 *12:25* A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Mt. Sinai Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE *MD.* B. COUNTY *Charles*

5. SEX *F* **6. RACE** *Negro* **7. MARRIED** ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH *5-8-95* **9. AGE** (In years last birthday) *76* **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country) *Chas. Co. Maryland* **12. CITIZEN OF WHAT COUNTRY? *U.S.A.***

13. FATHER'S NAME *Hildrey H. Wade* **14. MOTHER'S MAIDEN NAME** *Unknown Martha Washington*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **16. SOCIAL SECURITY NO.** *577-16-50340* **17. INFORMANT** *Rev. Robert Pittman, Sr.* ADDRESS *P.O. Box 4070 Wash. D.C.*

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE *Cerebral Vascular*
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH *1 hr.*

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION *9/10/71* **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** *None* **20A. AUTOPSY?** (Yes or No) ☐ **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) ☐ **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** While At Work ☐ Not While At Work ☐ **21F. HOW DID INJURY OCCUR?**

22. I certify that (I) (this hospital) attended the deceased from *8/30* **19** *71* **to** *9/9* **19** *71* **that (I) (we) last saw the deceased alive on** *9/9* **19** *71* **and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.**

23A. SIGNATURE *Edward D. Hallen* **23B. DATE SIGNED** *9/10/71*

23C. PHYSICIAN'S NAME (Type) **23D. ADDRESS** *6000 PARK HTS AV*

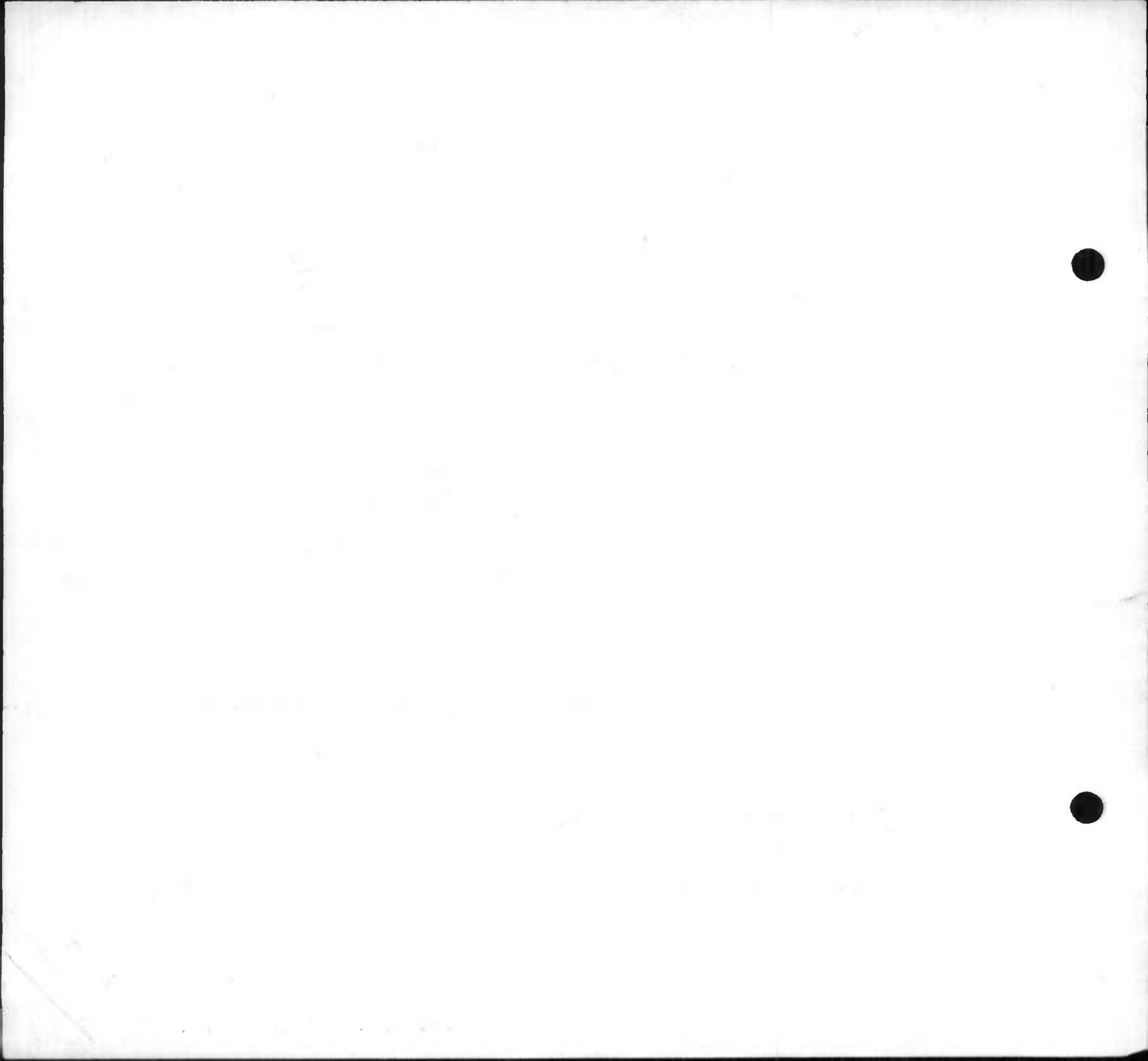
24A. BURIAL CREMATION, REMOVAL (Specify) *Burial* **24B. DATE** *9-14-71* **24C. NAME OF CEMETERY OR CREMATORY** *St. Peters Church* **24D. LOCATION** (City, town, or county) (State) *Waldorf, Maryland*

25A. DATE RECD. AT HEALTH DEPT. *SEP 17 1971* **25B. NAME OF REGISTRAR** *Robert E. Adams* **25C. FUNERAL DIRECTOR** *Martell Adams-Aguasce, Md.*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

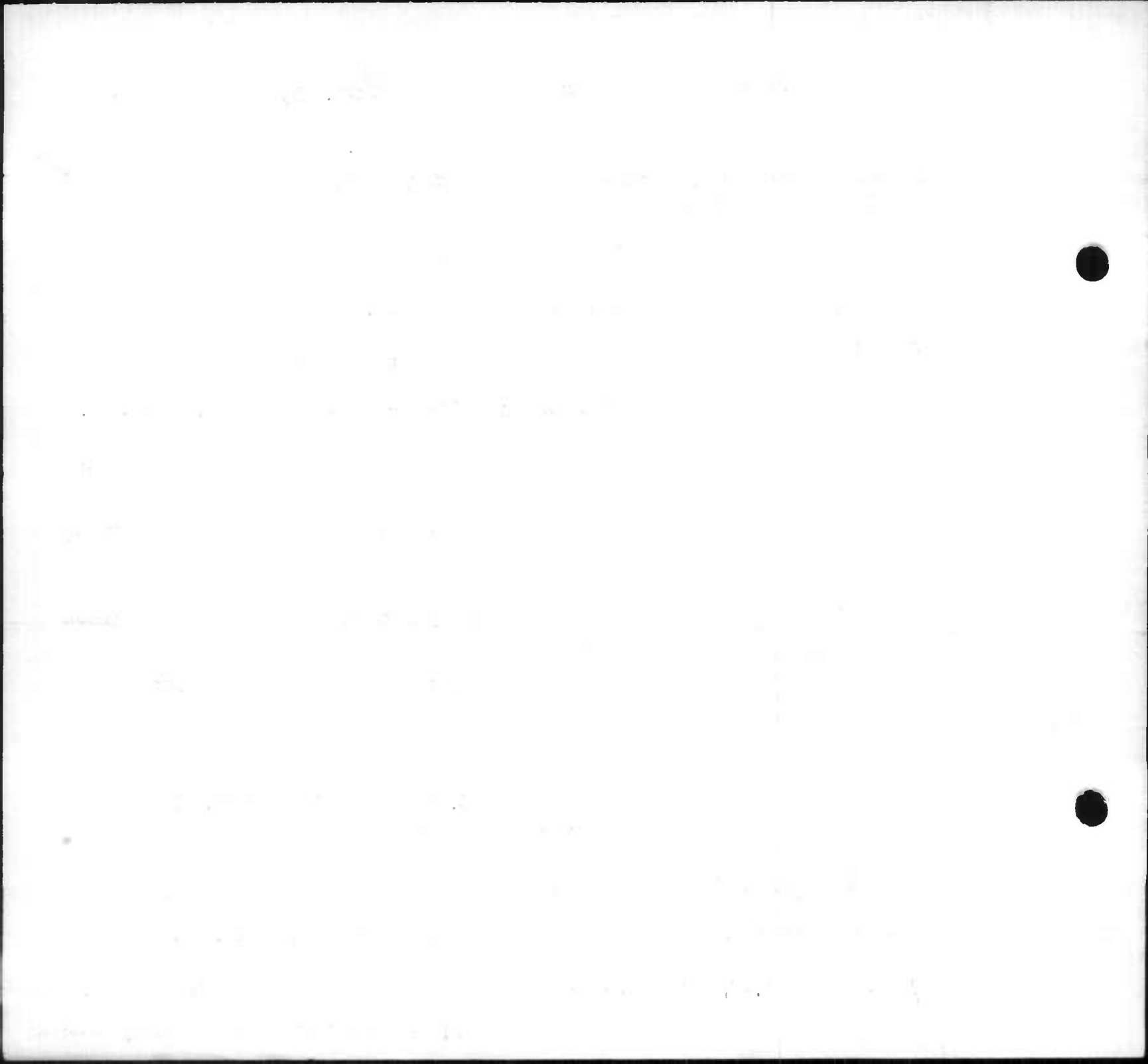
<p>BIRTH NO. S-354 71 8727</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 71 8727</p>			
<p>1. NAME OF DECEASED (Type or Print) Stanley, Rachel</p>		<p>2. DATE AND HOUR OF DEATH September 10 1971 3:00 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 1701</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 684 Pierce St</p>	
<p>5. SEX Female</p>	<p>6. RACE Negro</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 1930</p>
<p>9. AGE (In years last birthday) 41</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed</p>	<p>11. BIRTHPLACE (State or foreign country) Maryland</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME Albert H. Royer</p>	
<p>14. MOTHER'S MAIDEN NAME Lottie Stanley</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>	
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Thelma Louise Russell ADDRESS 617 N. Calhoun St.</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: etiology totally unknown</p> <p>(B) Chronic Brain Syndrome Months DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Alcoholism Years</p>	
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) Yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from August 11 1971 to September 10 1971 that (I) (we) last saw the deceased alive on September 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Lawrence Mills</p>		<p>23B. DATE SIGNED 9/10/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) LAWRENCE MILLS</p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Paridice</p>	
<p>24D. LOCATION (City, town, or county) (State) Trappe Talbot Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971</p>	
<p>25B. NAME OF REGISTRAR John E. Jaber, M.D.</p>		<p>25C. FUNERAL DIRECTOR The J.B. Dashiell F.H. ADDRESS P.O. Box 686 Eastern, Md.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-63671 8728		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 8728	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James Kenneth Crowder		Sept. 13, 1971 1:10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
US Public Health Service Hospital 2X 3100 Wyman Parkway			Md. St. Mary's 6800		
5. SEX M W			6. DATE OF BIRTH		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6/20/04 67		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Deckhand			Md. USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Crowder			Dulcue Chesser		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			215-20-3004		
17. INFORMANT			ADDRESS		
Records- US PHS Hospital, Balto, Md.					
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			Days		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Bronchopneumonia		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Emphysema		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II			Cor pulmonale		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Years		
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
2			yes		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
			yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept. 7 19 71 to Sept. 13 19 71 that (I) (we) last saw the deceased alive on Sept. 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
John C. Sutherland, M.D.			9/13/71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
John Sutherland, MD			US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		Sept. 15, 1971		St George Island Methodist St George Island, St Mary's, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 17 1971		Robert E. Taylor, R.D.		W. Clarke Mattingley Leonardtown, Maryland	



BIRTH NO.		1. NAME OF DECEASED (Type or Print) Helen Thomas		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 14 71 7:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1835 W. Lexington Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 14 71 7:10 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2001	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday) 23	11. BIRTHPLACE (State or foreign country) Roanoke Virginia		12. CITIZEN OF WHAT COUNTRY? USA
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY Restaurant		13. FATHER'S NAME Lee Thomas	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Dorothy Sanders	
18. INFORMANT MR Lee Thomas, 1602 Druid Hill Ave		ADDRESS		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Narcotic addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/18/71		24C. NAME of CEMETERY or CREMATORY MT Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR Adolphus H. Istead	
25C. FUNERAL DIRECTOR Adolphus H. Istead		ADDRESS 1200 W North Ave		VS 151-REV. 7/1/68	

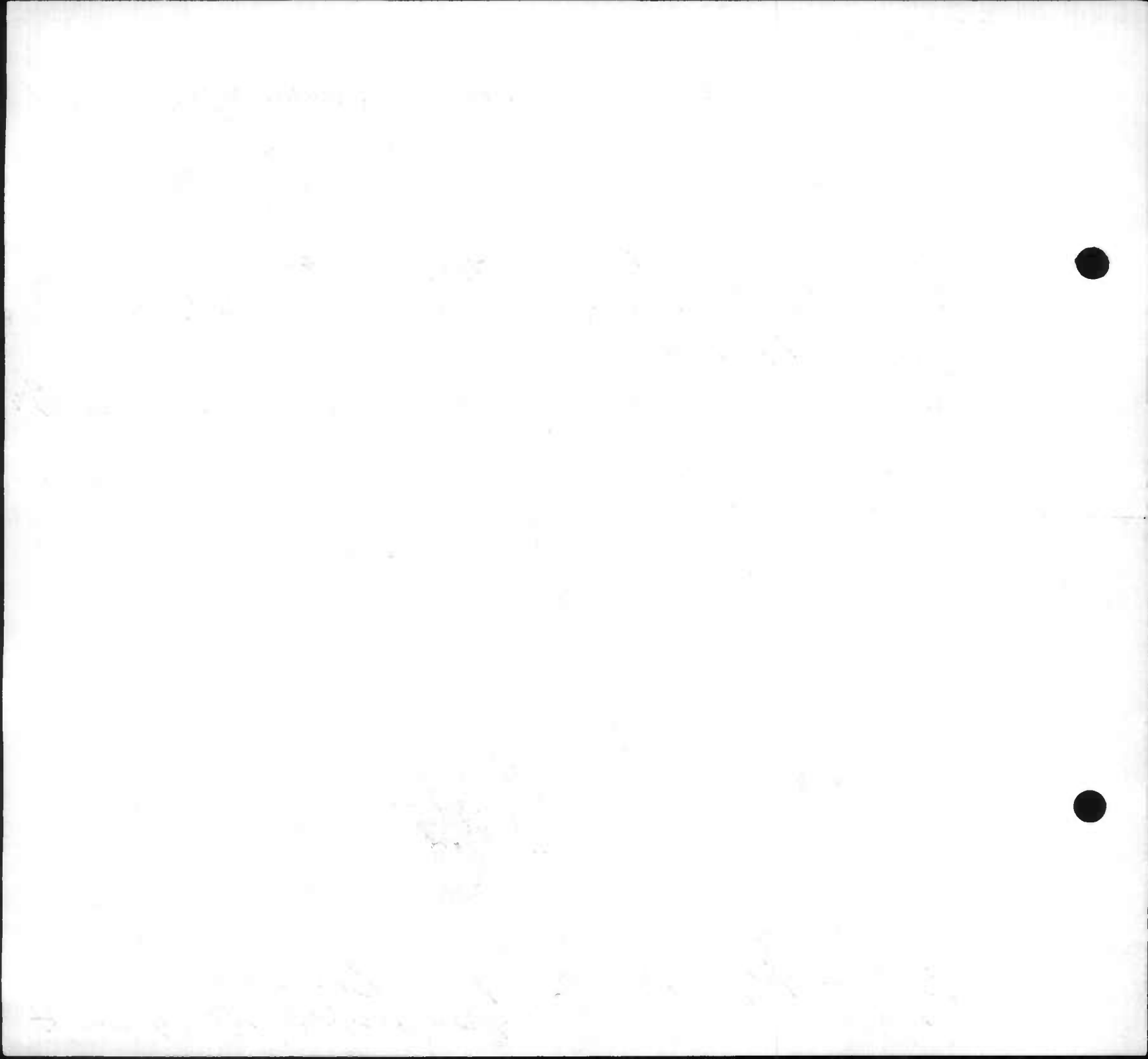
Letter from M.E.'s office

11-10-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 71 8731				REG. NO. _____	
BIRTH NO. <u>0-416</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ROSE OLIVER</u>		2. DATE AND HOUR OF DEATH <u>9-16-71</u> <u>10:10</u> a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Hilton Nursing Home 3313 Poplar St. Balto., Md. 21210</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1607</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3313 Poplar St</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1890</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker at Home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>EDWARD GAMBLES</u>			
14. MOTHER'S MAIDEN NAME <u>GRACE DODSON-TOMPSON</u>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-54-3654-1</u>		17. INFORMANT <u>GRACE DODSON-TOMPSON</u> Address <u>272</u>			
18. CAUSE OF DEATH <u>418.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>8-17-1971</u> to <u>9-16-1971</u> that (I) (we) last saw the deceased alive on <u>9-16-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED <u>9-16-71</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr. Hollis Seunarine</u> 23D. ADDRESS <u>1801 Greenberry Road Baltimore, Maryland</u> 24A. BURIAL OR REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>9/20/71</u> 24C. NAME OF CEMETERY or CREMATORY <u>Gambles Family</u> 24D. LOCATION (City, town, or county) (State) <u>A.A. Co. Md</u> 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u> 25C. FUNERAL DIRECTOR <u>Robert E. Taylor, Jr.</u> 25D. ADDRESS <u>1350 G. & M.</u>					

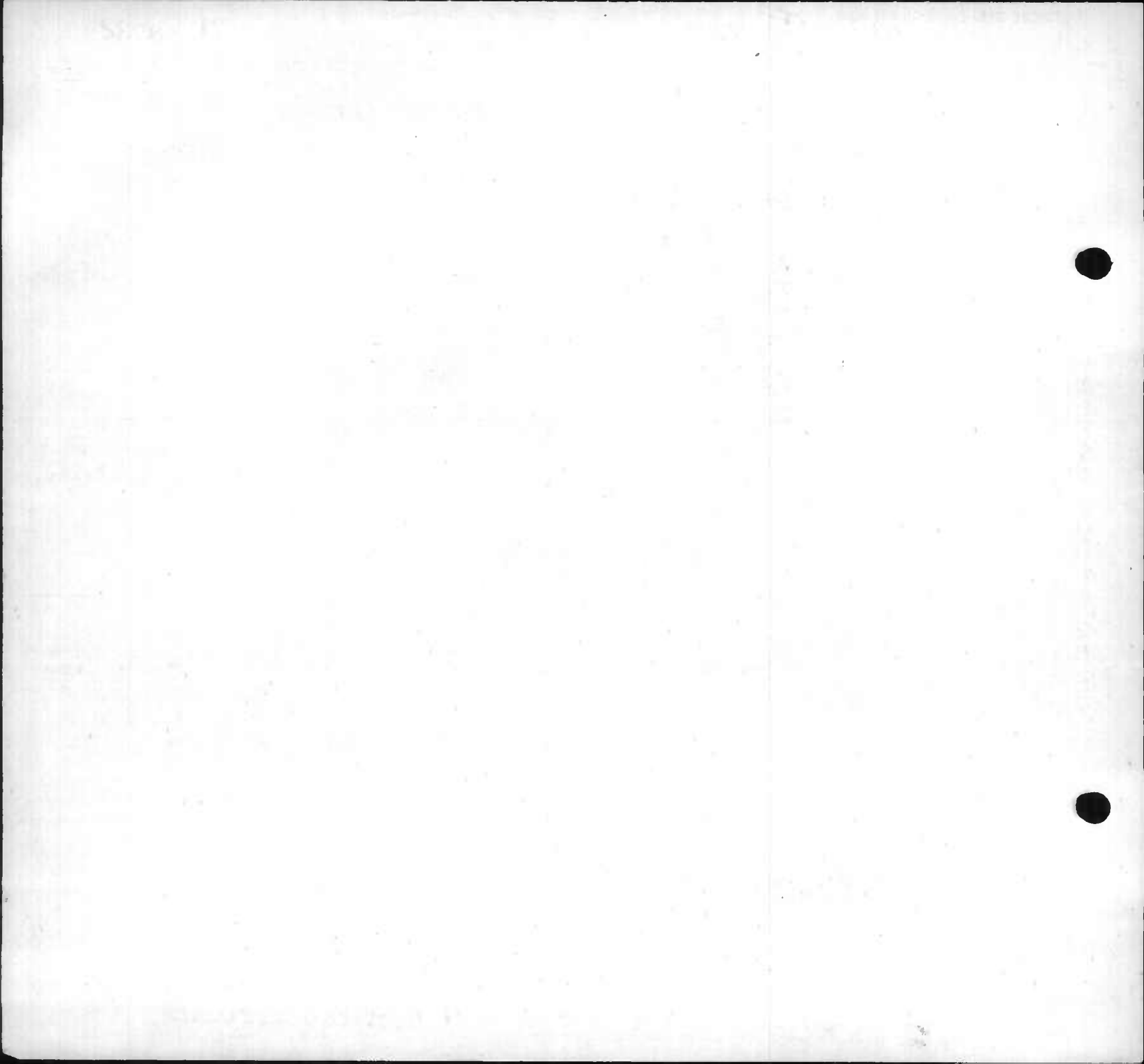
Came to Milton N. H.

from Cornwall State Hosp.
ask. as to how long patient
was there. no former address
given. CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

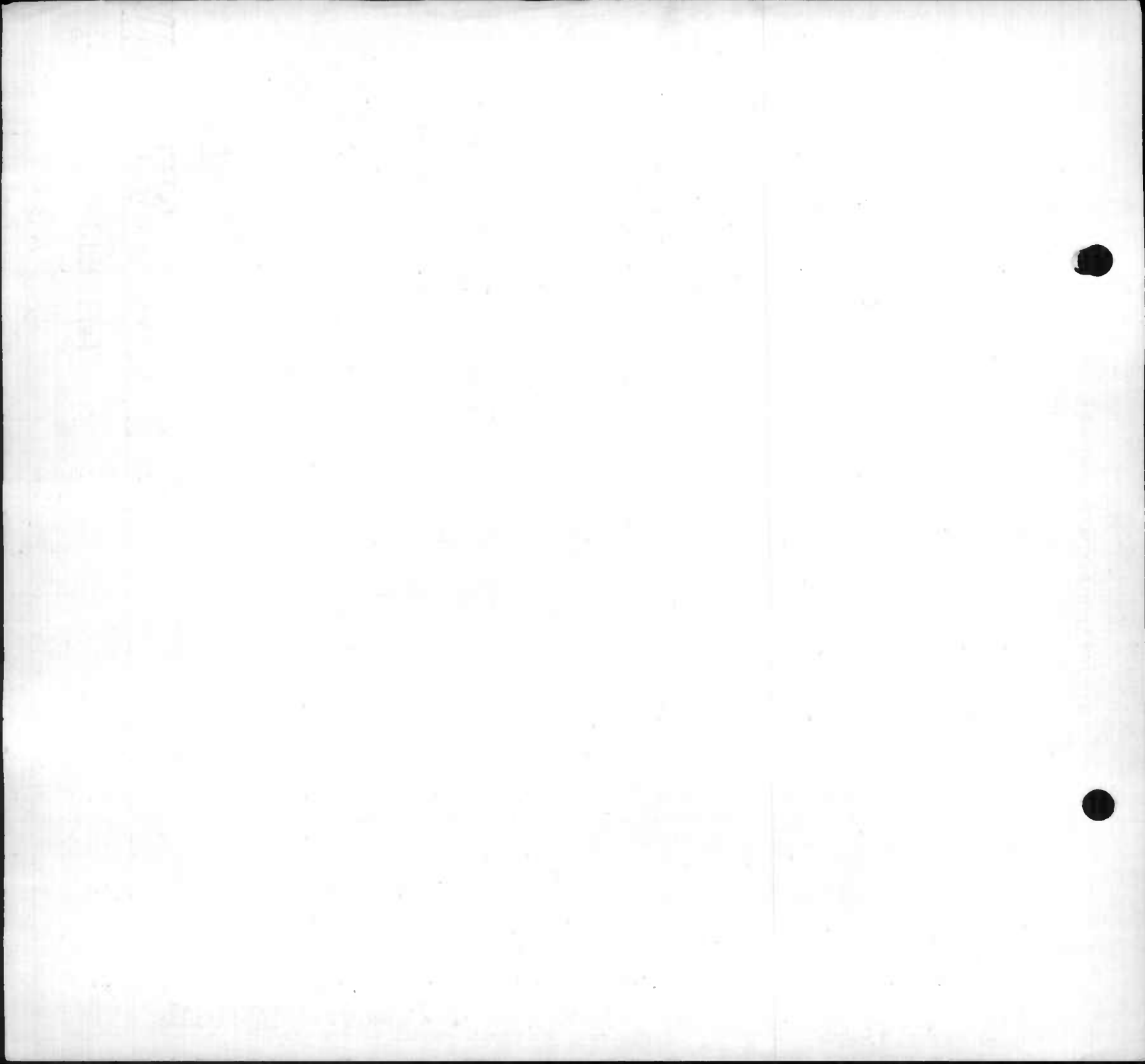
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8732 4	
P-400 71 8732				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) TWIN B Powell BABY BOY		2. DATE AND HOUR OF DEATH 9/14/71 3:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2131 HOLLINS ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/71	9. AGE (In years last birthday) 2 16	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME CEPHUS POWELL		14. MOTHER'S MAIDEN NAME CYNTHIA JONES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER	
18. 769.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURITY - 1 lb. 5 1/2 oz. newborn		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity - 1 lb. 5 1/2 oz. newborn			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/14/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12:45 PM 9/14/71 to 3:14 PM 9/14/71 , that (I) (we) last saw the deceased alive on 3 PM 9/14/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edwin H.T. Besson				23B. DATE SIGNED 9/14/71	
23C. PHYSICIAN'S NAME (Type) Edwin H.T. Besson				23D. ADDRESS 804 B Ingleside Ave Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 9/15/71		24C. NAME OF CEMETERY or CREMATORY Bon Secours Hospital	
24D. LOCATION (City, town, or county) (State) 2025 W. Fayette St. Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR John E. Bess	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

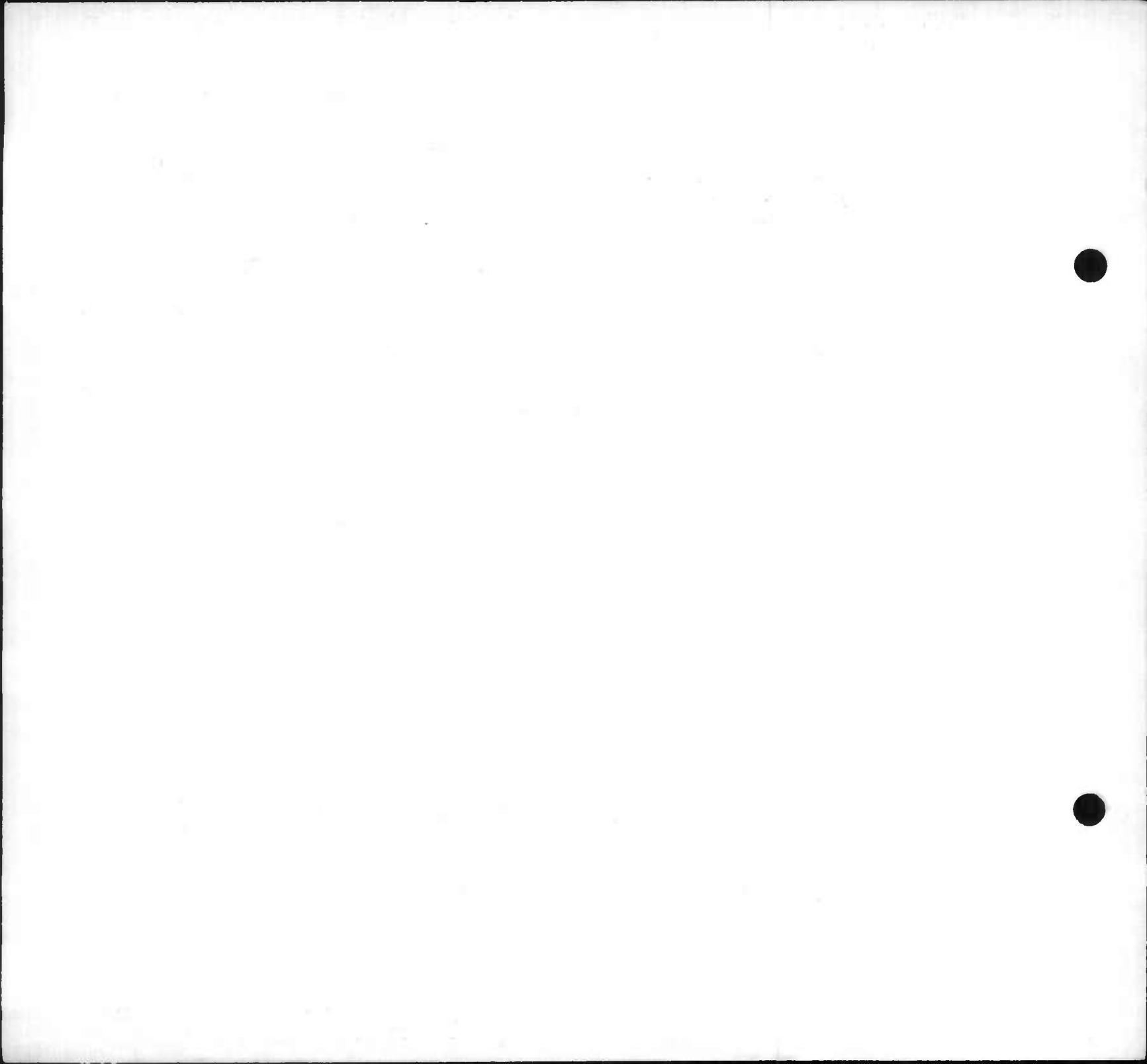
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8733 4</u>	
BIRTH NO. <u>71-15641 8733</u> 1. NAME OF DECEASED (Type or Print) <u>TWIN A Powell, Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>9/14/71</u> <u>2 PM</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2004</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2131 HOLLINS St.</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/14/71</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>1</u> <u>30</u>	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>CEPHUS POWELL</u>				14. MOTHER'S MAIDEN NAME <u>CYNTHIA JONES</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Prematurity 1 lb. 6 oz Newborn</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12³⁰ 9.14</u> to <u>9.14 1971</u> , that (I) (we) last saw the deceased alive on <u>2⁰⁵PM 9.14 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Edwin H.T. Besson</u>				23B. DATE SIGNED <u>9/14/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Edwin H.T. Besson</u>	
23D. ADDRESS <u>504 B Ingleside Ave. Baltimore Md 21228</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> 24B. DATE <u>9/15/71</u> 24C. NAME OF CEMETERY OR CREMATORY <u>BON SECOURS Hosp.</u> 24D. LOCATION (City, town, or county) (State) <u>2025 W. Fayette St. Balt. Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Baker, Md.</u>		25C. FUNERAL DIRECTOR <u>4</u>		ADDRESS <u>HOSPITAL DISPOSAL</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>C-350 71 8734</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8734</p>	
<p>BIRTH NO.</p>				<p>2. DATE AND HOUR OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print) Beulah COTTON</p>				<p>September 15, 1971 9:35 P M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland</p>				<p>A. STATE Maryland B. COUNTY 402</p>			
<p>C. CITY OR TOWN Baltimore</p>				<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>E. STREET AND NUMBER 734 W. Fayette Street</p>							
<p>5. SEX F</p>		<p>6. RACE B</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 5/28/95</p>	
				<p>9. AGE (In years last birthday) 76</p>		<p>10. Under 1 Yr. Months 11. Under 24 Hrs. Days</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) North Carolina</p>	
				<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>			
<p>13. FATHER'S NAME Alfred Jones</p>				<p>14. MOTHER'S MAIDEN NAME Susie Spence</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>				<p>16. SOCIAL SECURITY NO. 244-01-9313-</p>		<p>17. INFORMANT ADDRESS 21201 Mrs. Gladys Jones 734 W. Fayette St. Apt. 105</p>	
<p>18. CAUSE OF DEATH</p>							
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) A.S.C.V. Disease. DUE TO, OR AS A CONSEQUENCE OF: (C)</p>			
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days ?</p>							
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from August 9 19 71 to September 15 19 71 that (I) (we) last saw the deceased alive on September 14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE <i>Joseph S. Blum</i></p>				<p>23B. DATE SIGNED 9/16/71</p>			
<p>23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD</p>				<p>23D. ADDRESS 1115 N. CALVERT ST.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial</p>		<p>24B. DATE 9-19-71</p>		<p>24C. NAME of CEMETERY or CREMATORY Bazzel Creek Church Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Fuguay Spr., N. Carolina</p>	
<p>25A. DATE REC'D BY HEALTH DEPT SEP 17 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS Marshall W. Jones, Jr.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-530 71 8735		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8735	
1. NAME OF DECEASED (Type or Print) SMITH, Ethel C.			2. DATE AND HOUR OF DEATH 9/14/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 706 Dolphin Street Baltimore, Md. 21217			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1703 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 706 Dolphin Street		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/08	9. AGE (In years, lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY HUTZLER'S STORE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME GEORGE JACKSON			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-10-6795		17. INFORMANT (Name) VIOLA HARRISTON ADDRESS 1523 N. Milton Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DUE TO, OR AS A CONSEQUENCE OF: DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE FAILURE, HYPERTENSION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/31 19 69 to 9/14 19 71 that (I) (we) last saw the deceased alive on 9/14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE GILBERT L. BANFIELD				23B. DATE SIGNED 9/16/71	
23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD MD				23D. ADDRESS 722 N. Juleen Ave. Balt.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/17/71		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND 21227		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTON & DYE FUNERAL HOMES, INC. 1701-31 Laurens St., Balto., Md. 21217			

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8736
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY L. BYRD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001368 N. Stricker St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 13 1971 9:50 a.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1501	
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10-7-00	10. AGE (In years last birthday) 70	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 1368 N. Stricker St.	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)	
17. SOCIAL SECURITY NO. 218-01-7303		18. INFORMANT Lillian Green		ADDRESS 1366 Stricker St.	
19. 712.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/13/71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-17-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR V. E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Nelson Funeral Home		25D. ADDRESS 1348 N. Calhoun St.			

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ACADEMIC RECORD
EXAMINATION
DATE
PAGE NO

Branch is M.A. History, Govt. College, Aligarh

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P-62071 8737

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8737

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH PRICE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

September 14, 1971

3:23 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

806

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

A49.5.1902

10. AGE (In years
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1726 N. Broadway

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Israel Price

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Jane Adams

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Bessie Price - 1726 N. Broadway

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Pulmonary Tuberculosis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S Ronald N. Kornblum, M.D.

NAME (Type)

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

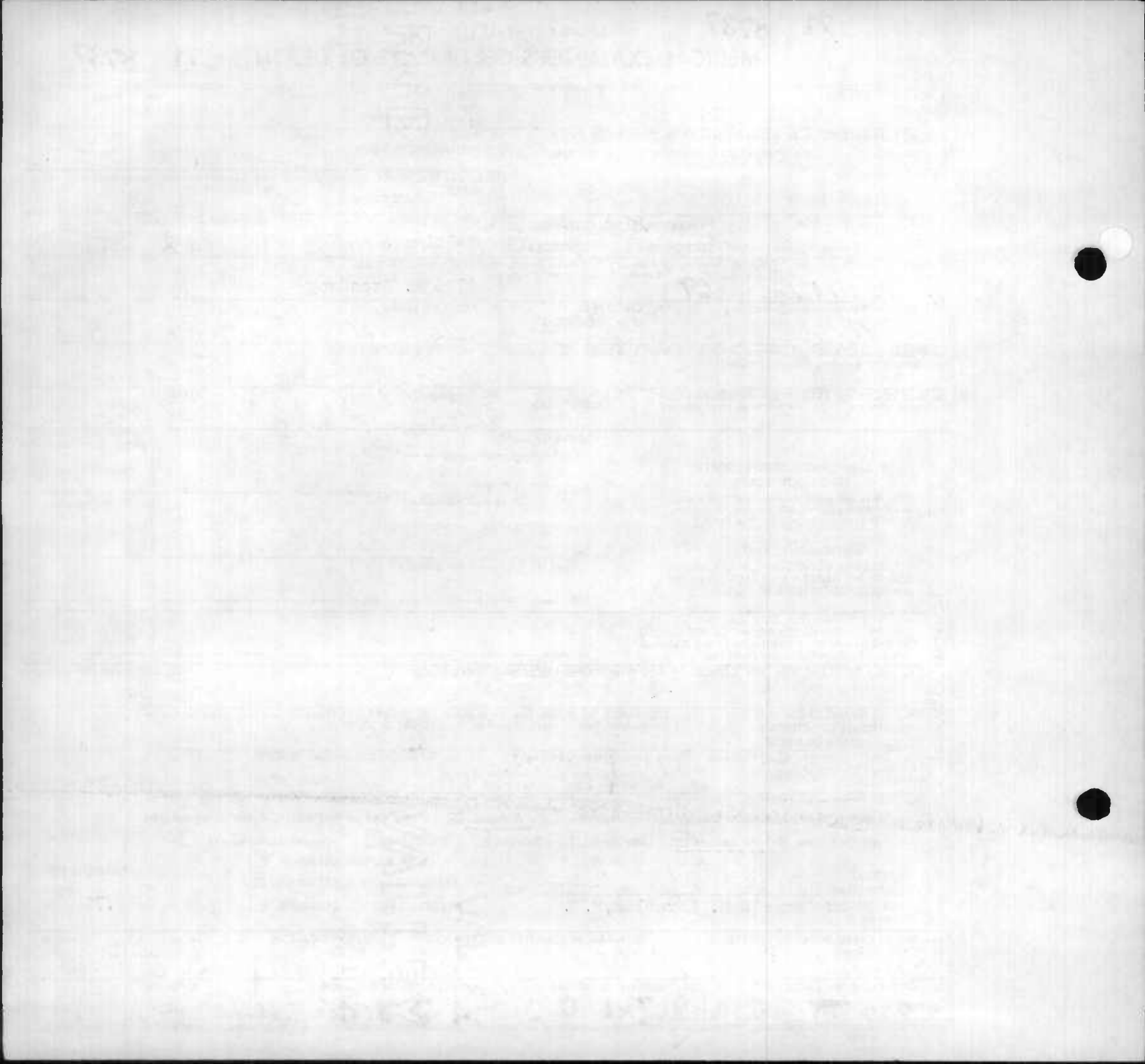
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

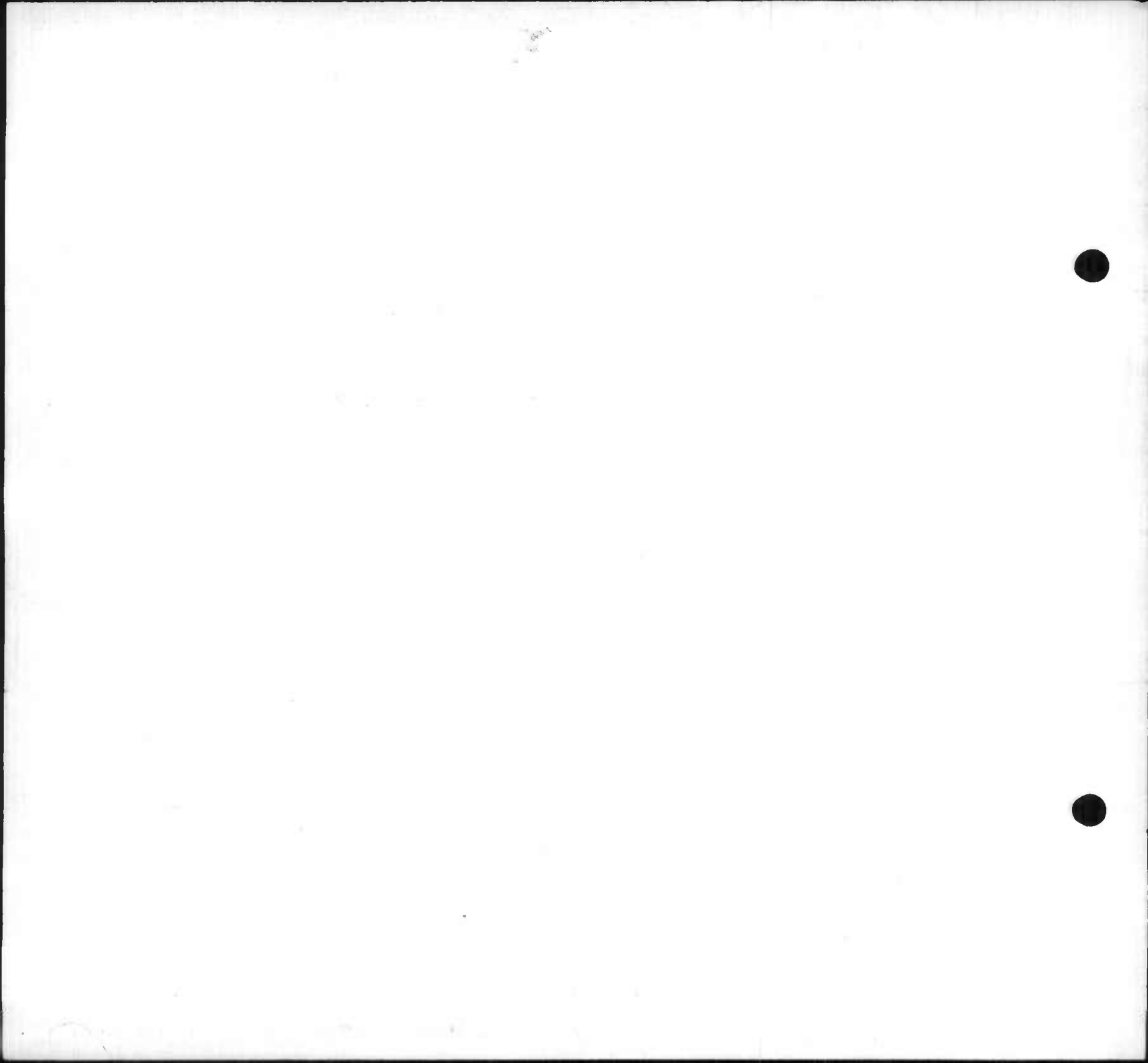
SEP 17 1971



FUNERAL DIRECTOR: IMPORTANT

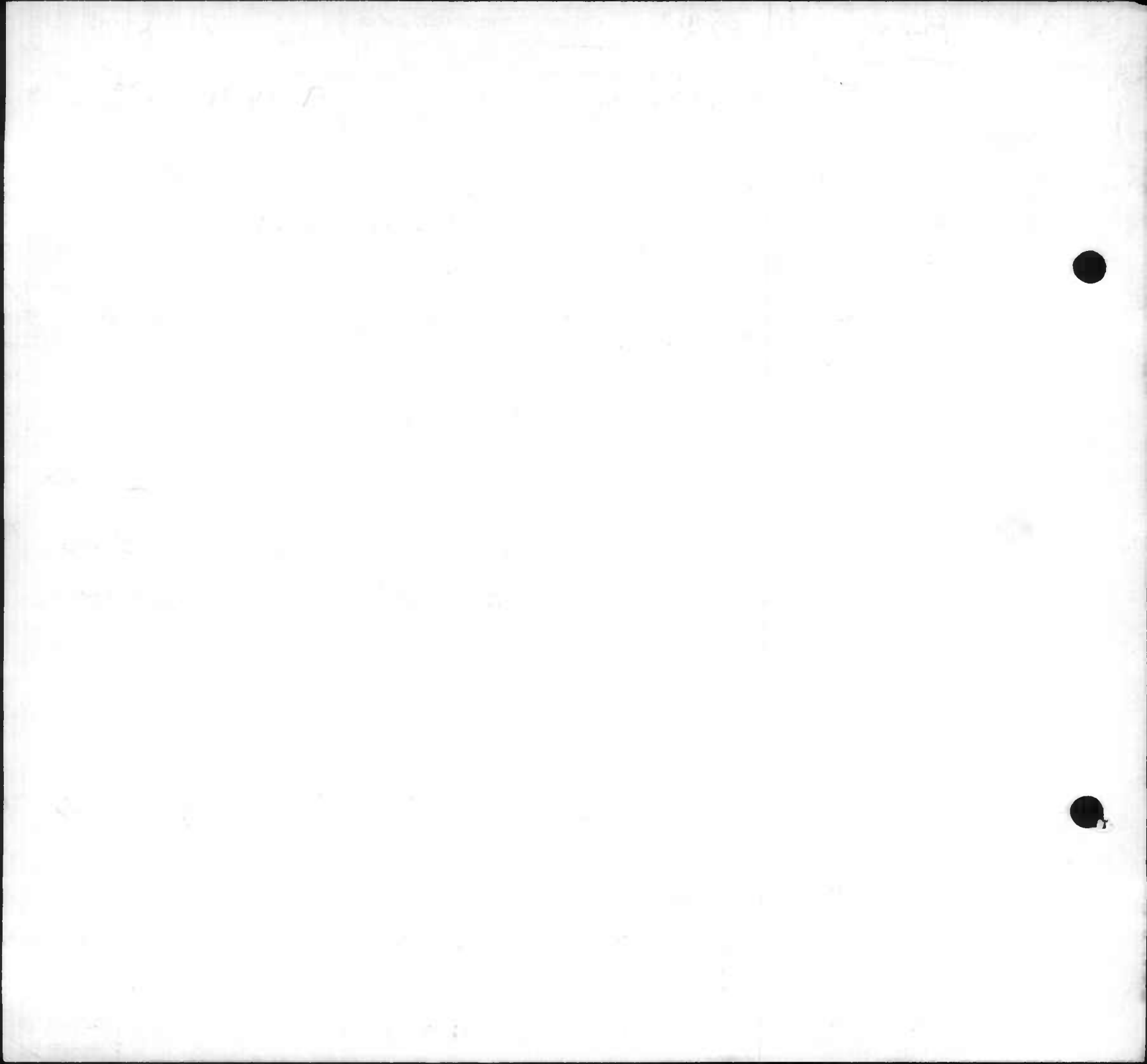
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8738</u>	
<p>B-630 <u>md.</u> <u>71 8738</u></p> <p>BIRTH NO. <u>24</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>BOWARD, JO ANN</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9 14 71</u> <u>9 28 P. M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u></p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>MD</u> B. COUNTY <u>WASH</u></p> <p><u>147 S LOCUST STREET HAGERSTOWN.</u></p> <p>C. CITY OR TOWN <u>HAGERSTOWN.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>7103</u></p> <p>E. STREET AND NUMBER</p>			
<p>5. SEX <u>Female</u> 6. RACE <u>white</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1-13-67</u> 9. AGE (in years last birthday) <u>4 YRS.</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>ROBERT BOWARD</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>LINDA ARVIN.</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u> If yes, give war or dates of service</p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>Robert D. Boward</u> ADDRESS <u>Hagerstown, Md.</u></p>			
<p>18. <u>74691</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>CARDIAC ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>CONGENITAL HEART DISEASE.</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>9/12/71</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> 19 <u>71</u> to <u>9/14</u> 19 <u>71</u> that <u>we</u> lost saw the deceased alive on <u>9/14/71</u> 19 <u>71</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>we</u> (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Dr. Gopal Krishnan</u></p>		<p>23B. DATE SIGNED <u>9 14 71</u></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>DR. GOPALA KRISHNAN</u></p>		<p>23D. ADDRESS <u>UNIVERSITY HOSPITAL</u></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u></p>		<p>24B. DATE <u>9-18-71</u></p>		<p>24C. NAME of CEMETERY or CREMATORY <u>Rest Haven Cemetery</u></p>	
<p>24D. LOCATION (City, town, or county) <u>Hagerstown, Md.</u></p>		<p>24E. STATE (State) <u>Md.</u></p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>R. E. Taylor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Minnich Funeral Home</u></p>	
<p>25D. ADDRESS <u>Hagerstown, Md.</u></p>		<p>VS 150-REV. 11/68</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

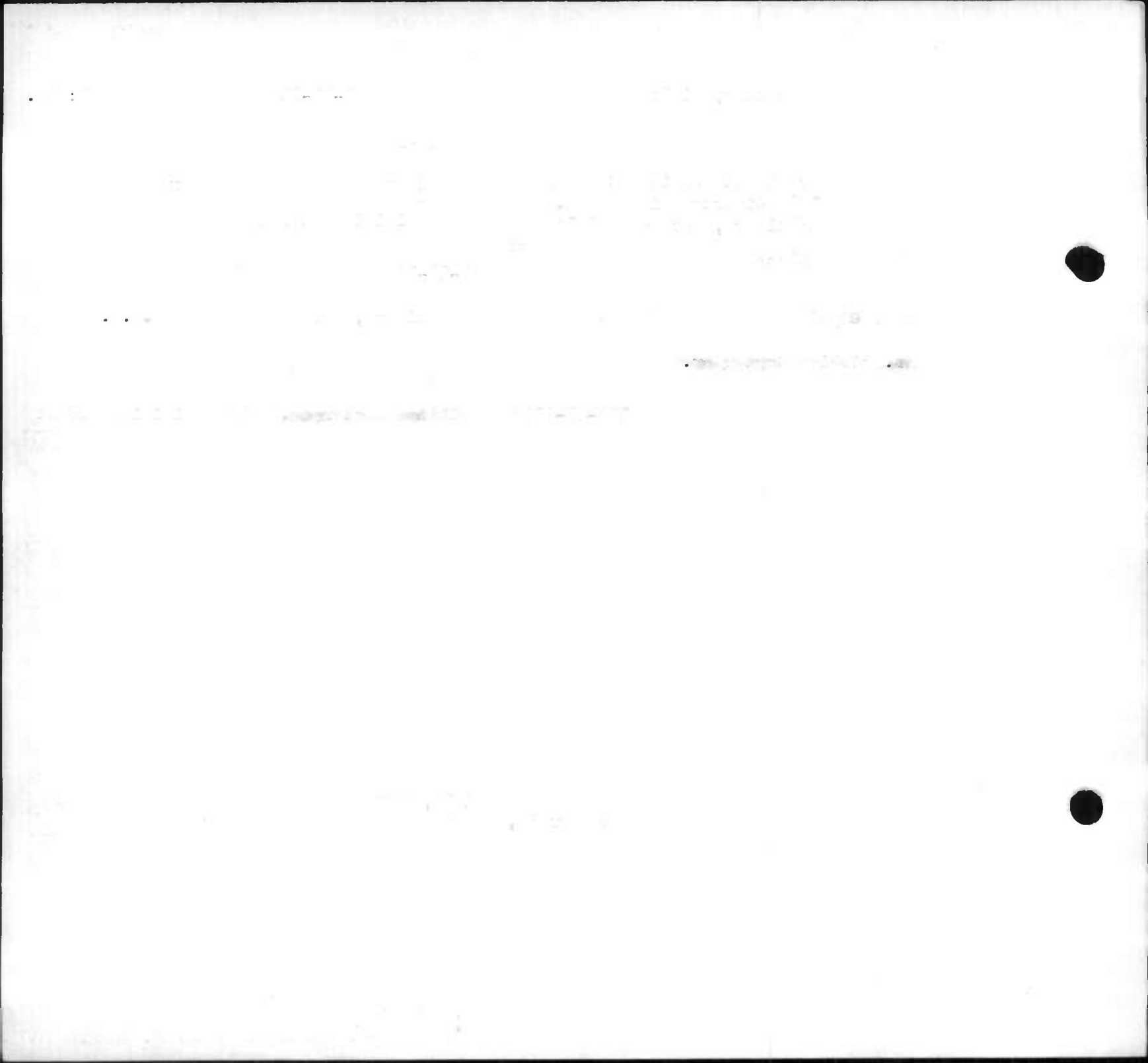
B-622 71 8739		BALTIMORE CITY HEALTH DEPARTMENT		71 8739	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>ESTELLE BORSUKIEWICZ</u>		2. DATE AND HOUR OF DEATH <u>9-16-71</u> <u>4:25</u> PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Harbor View Convalescent Center</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>202</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harbor View Convalescent Center</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1815 Bough St.</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/05</u>	9. AGE (In years last birthday) <u>66</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Andrew Stanczak</u>		14. MOTHER'S MAIDEN NAME <u>Wielhorski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-5039A</u>		17. INFORMANT <u>Sandra Nelson</u> ADDRESS <u>2116 2nd St</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Septic embolic pneumonia</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>69</u> to <u>9/16</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ak</u>		23B. DATE SIGNED <u>9/17/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MAECHT MD</u>		23D. ADDRESS <u>2 E Paul St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/20/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jaber, Jr.</u>		25C. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 Eastern Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

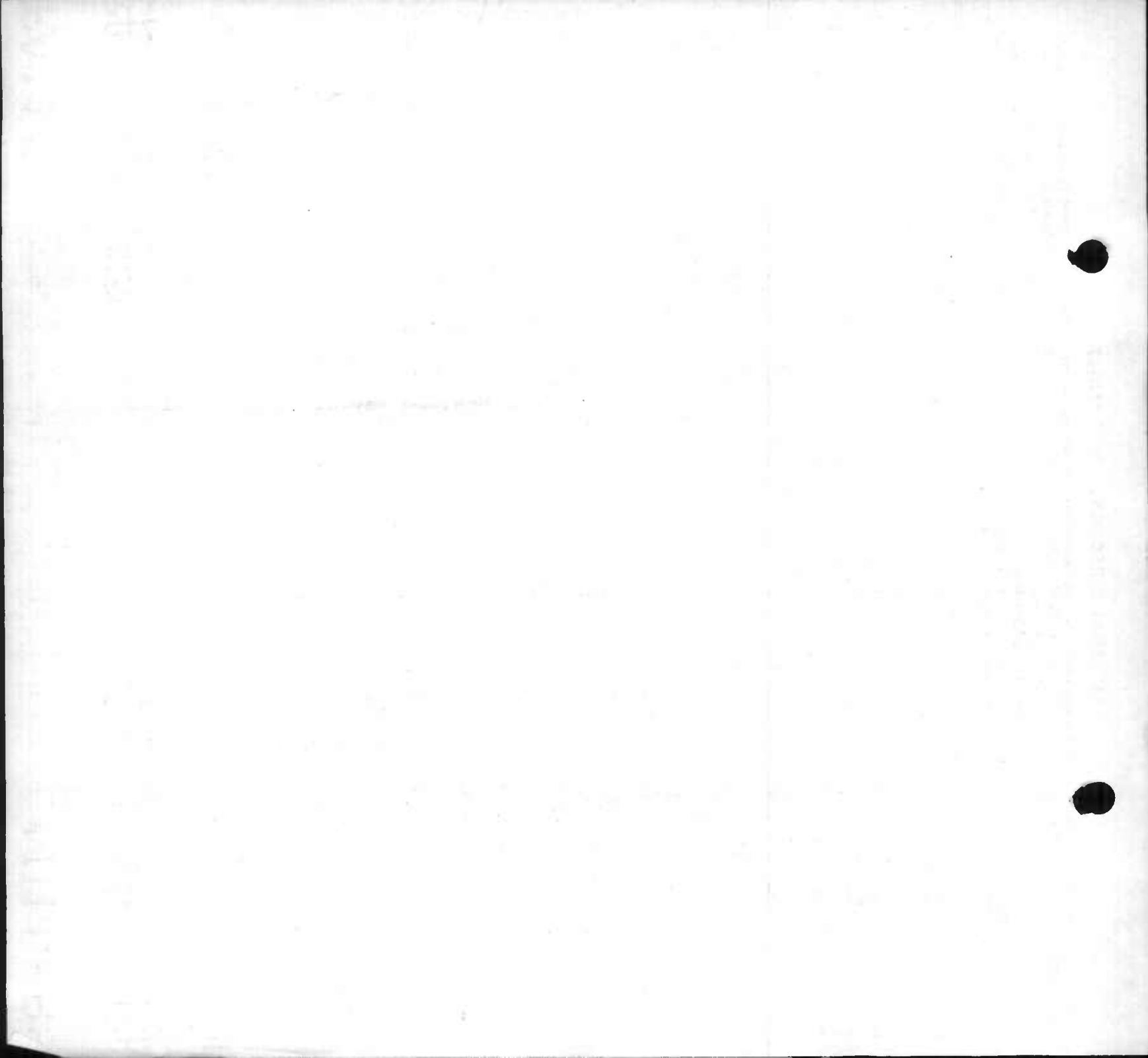
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8740	
C-636 71 8740		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Carter, William Earl		9-11-71 4:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-23-14 9. AGE (In years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10B. KIND OF BUSINESS OR INDUSTRY Construction		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Carter		14. MOTHER'S MAIDEN NAME Bertinia Butler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-4275	
17. INFORMANT William H. Carter		ADDRESS 1908 Division Street	
18. 571.0 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Arteriosclerosis		4 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Ethanol Intoxication		17 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 9-11-71		20A. AUTOPSY? (Yes or No) No	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 26, 1971 to Sept 11, 1971 that (I) (we) last saw the deceased alive on September 11, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Boon Vanasin		23B. DATE SIGNED Sept 13, 71	
23C. PHYSICIAN'S NAME (Type) BOON VANASIN		23D. ADDRESS Provident Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 17 1971		25B. NAME OF REGISTRAR John E. Allen, MD.	
25C. FUNERAL DIRECTOR'S ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

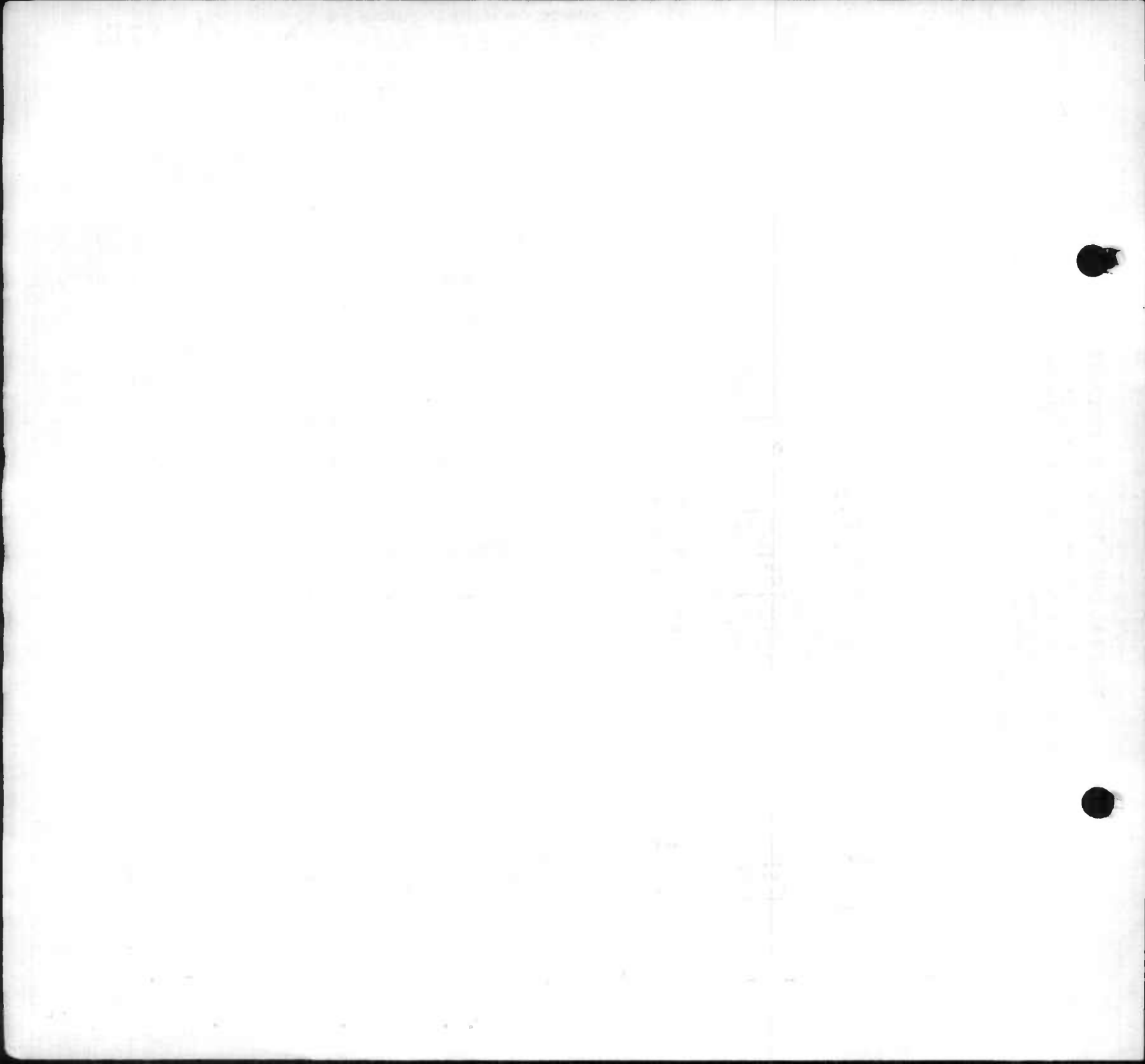
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8741</u>	
S-322 71 8741				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <u>John T. Stokes</u>			2. DATE AND HOUR OF DEATH <u>September 14, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 2051 Wheeler Avenue</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1504</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2051 Wheeler Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-1902</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Stokes</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Shelton</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-7034</u>	17. INFORMANT <u>Mrs. Le Ray S. Stokes</u> ADDRESS <u>2051 Wheeler Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Pancreas</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>7 infarctoses</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Pancreas</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>7 infarctoses</u> (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/8/71</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/2/70</u> 19 <u>70</u> to <u>8/14/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/7</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore C. Patterson</u>			23B. DATE SIGNED <u>9-14-1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>Theodore Patterson</u>			23D. ADDRESS <u>M. D. 3427 Dundalk Avenue</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-18-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1971</u>		25B. NAME of REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>NOTTER FUNERAL HOME 3035 W. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

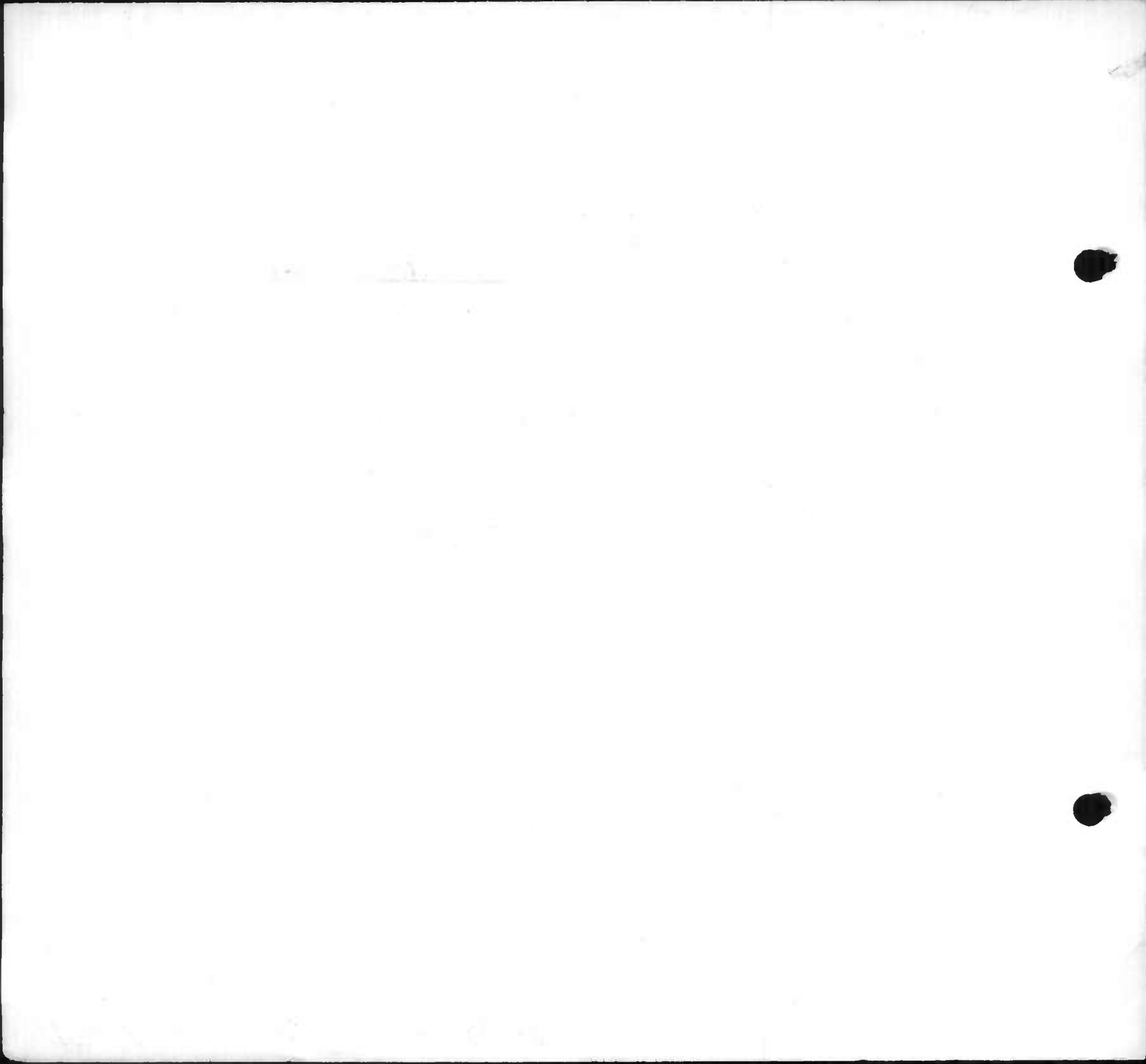
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8742	
BIRTH NO. P-612 71 8742		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Silvia Purvis		2. DATE AND HOUR OF DEATH 9/14/71 ?			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 933 S. HANOVER ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-30 9. AGE (in years last birthday) 40 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) State	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME DEC. HENRY PURVIS 14. MOTHER'S MAIDEN NAME HAZEL WALLACE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER - ALETA FLOYD ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A-4-12-1					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II CORONARY ART. INJURY					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSION ASCVD CARDIOMEGALY					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-61 to 8/13/71 19 71 that (I) (we) last saw the deceased alive on 8/13/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 9/14/71		23C. PHYSICIAN'S NAME (Type) M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9-18-71		24C. NAME OF CEMETERY OR CREMATORY Brown's A.M.E. Church Yd		24D. LOCATION (City, town, or county) (State) Calvert County-Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Idl. Brown & Son-I23 W. Montgomery St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

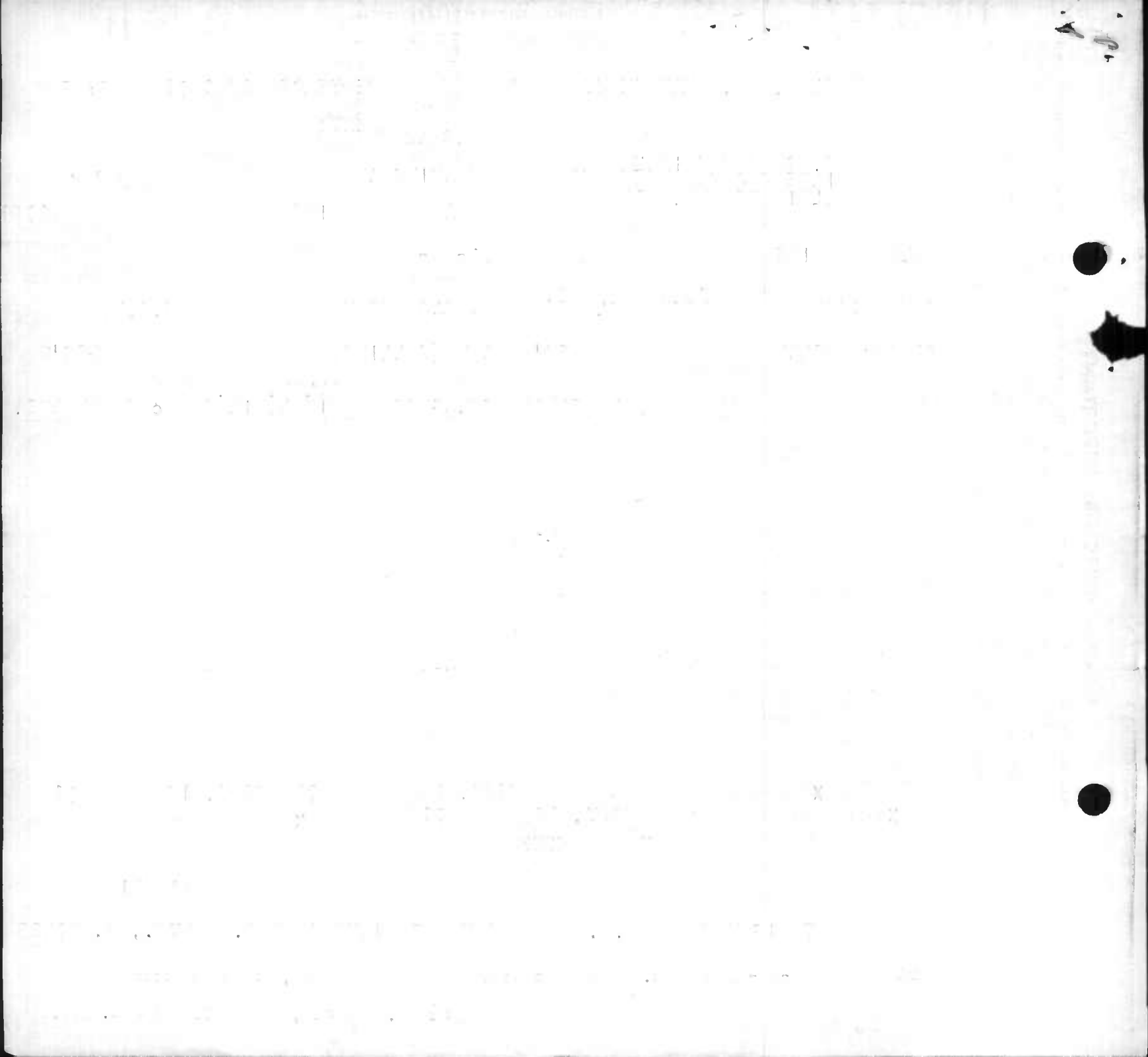
H-536 71 8743		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 8743 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENDERSON JULIA		2. DATE AND HOUR OF DEATH 9.19.71 1 800 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 2798		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. INC - BALTIMORE		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 3221 W. GARRISON AVE	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.5.10	9. AGE (in years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROWLAND N.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME TOM TOWNSEND		14. MOTHER'S MAIDEN NAME LIZZIE BAKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 243-16-4732		17. INFORMANT MARY ROGERS 3221 W GARRISON AVE	
18. 4/12/41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nally medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-9 1971 to 9-19 1971 that (I) (we) last saw the deceased alive on 9.19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Marco Varini, MD		23B. DATE SIGNED 9.19.71		23C. PHYSICIAN'S NAME (Type) MARCO VARINI, MD	
23D. ADDRESS SINAI HOSP. INC - BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) Removal			
24B. DATE 9/22/71		24C. NAME OF CEMETERY or CREMATORY FAMILY Plot		24D. LOCATION (City, town, or county) (State) ROWLAND N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR E. Salter, M.D.		25C. FUNERAL DIRECTOR P. Hayes 635 N. G. L. Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

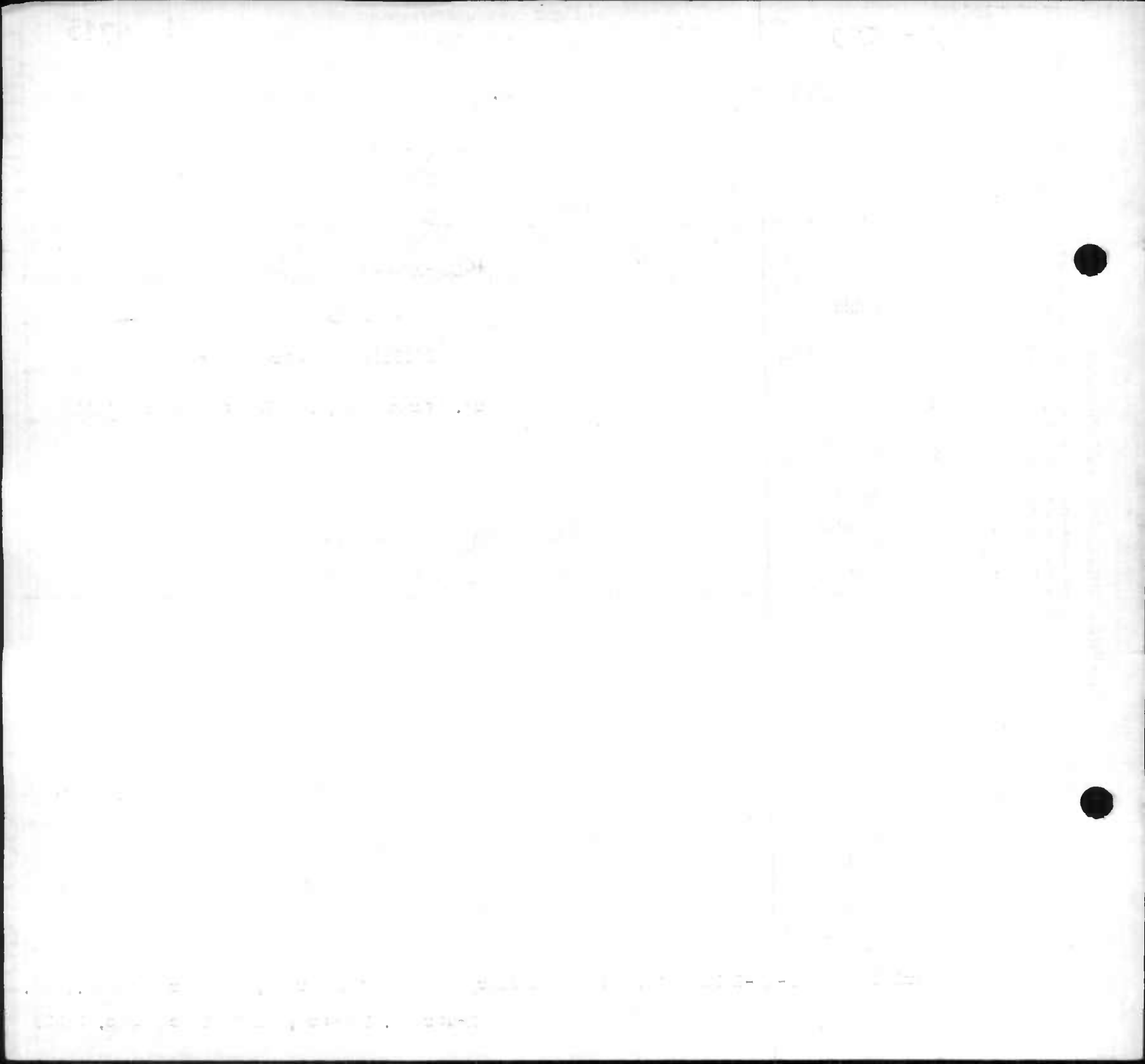
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8744</u>	
U-450 71 8744		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WHELAN, SR. MATHEW JOHN		SEPTEMBER 15, 1971 5:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MASSACHUSETTS		V-18	
ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MD. 21229		C. CITY OR TOWN FRAMINGHAM		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
40		E. STREET AND NUMBER 9 ASHMONT DRIVE		01701	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-09-09	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPOSITOR		10B. KIND OF BUSINESS OR INDUSTRY BOSTON MASS. BOSTON GLOBE		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
13. FATHER'S NAME FENTON WHELAN		14. MOTHER'S MAIDEN NAME ANN (COLLINS)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 029057414		17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying. heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1 Failure of Permanent Pacemaker 2 Anterior and Septal Myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: 3 Acute Pancreatitis 4 Cerebral infarct - 5 Ch. Discoid Lupus. (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPT. 10 19 71 to SEPT. 15 19 71 that (X) (we) last saw the deceased alive on SEPT. 15 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE TARIG MAHMOOD M.D.				23B. DATE SIGNED 9/16/71	
23C. PHYSICIAN'S NAME (Type) TARIG MAHMOOD M.D.				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-18-1971		24C. NAME of CEMETERY or CREMATORY St. Joseph Cemetery	
24D. LOCATION Roxbury, Massachusetts		24E. NAME of REGISTRAR SEP 20 1971		24F. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8745</u>	
L-520 71 8745				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LUNCH, XXX SARAH A.</u>		2. DATE AND HOUR OF DEATH <u>SEPTEMBER 15, 1971 4:40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>444 UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1203</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>444 UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2435 ST. PAUL ST.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1897</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Boyd</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Marie Wolf, 565 Lucia Avenue 21229</u>	
18. <u>1957 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY INSUFFICIENCY</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY METASTASES</u> (B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(C) PELVIC CANCER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 14, 1971</u> to <u>SEPTEMBER 15, 1971</u> that (I) (we) lost saw the deceased alive on <u>SEPT. 15, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>SEPT 15, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>CESAR VIVARON</u>		23D. ADDRESS <u>INTER. DEGREE 33rd and Calvert ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-17-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION <u>Glen Burnie, Anne Arundel Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Naber, #101</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



W-560 71 8746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 8746

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Max J. Wiener

2. DATE AND HOUR OF DEATH

9/15/71

1:00 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

Anne Arundel

C. CITY OR TOWN

Linthicum

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

524 Cleveland Road

21090

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

10-2-1898

9. AGE (In years
last birthday)

72

XX

10. Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Wiener

14. MOTHER'S MAIDEN NAME

Eva Prunkel

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-07-2400

17. INFORMANT

Mr. Max N. Wiener, 2031 Edmondson Ave. 21228

Records: BCH-4940 Eastern Avenue

21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

25% 3rd degree BURN

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☒
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOME

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

LINTHICUM HTS 5208

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
9 11 71 10P

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

fell backward in bathtub, head
hit water

22. I certify that (I) (this hospital) attended the deceased from 9/12 1971 to 9/15 1971
that (I) (we) last saw the deceased alive on 9/15/71 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jean Pierre Schuppisser

DEGREE

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

9-15-1971

23C. PHYSICIAN'S
NAME (Type)

Jean Pierre Schuppisser

DEGREE

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.

BALTO CITY HOSPITALS

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-18-1971

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1971

25B. NAME OF REGISTRAR

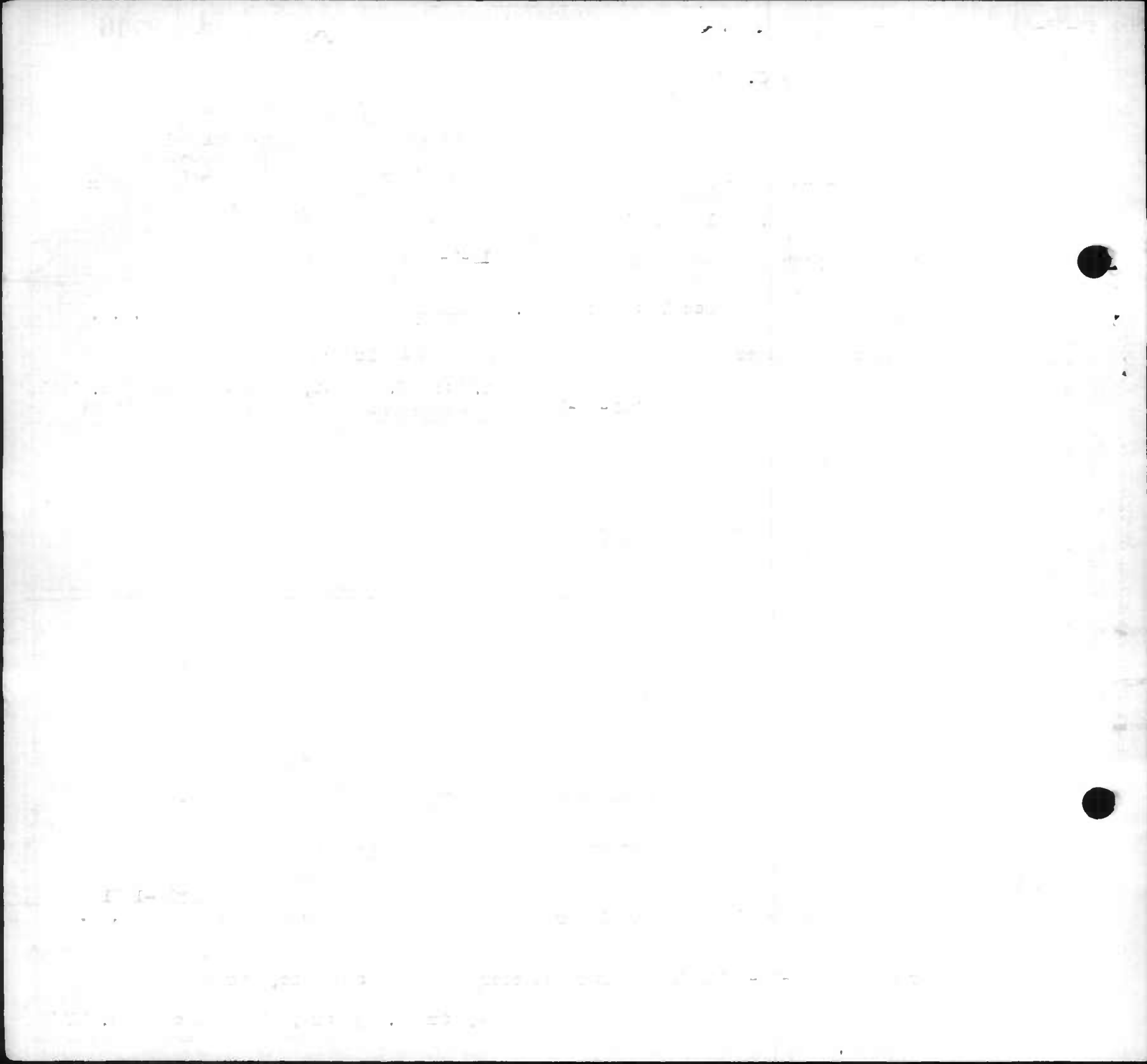
25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

RELEASED ON APPROVAL BY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-40071 8747		CERTIFICATE OF DEATH		REG. NO. 71 8747	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BUHL, GEORGE O		2. DATE AND HOUR OF DEATH SEPTEMBER 17, 1971 12:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN JANS DOWNE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 01/25/04		9. AGE (In years last birthday) 67		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHECKER		10B. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME LOUIS BUHL		14. MOTHER'S MAIDEN NAME HENRIETTA BRINKER BUHL	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 217-07-3587		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 1971.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Metastatic Carcinoma			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Pulmonary Emphysema, A.S.C.U.D.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 2 19 71 to SEPTEMBER 17 19 71 that (I) (we) last saw the deceased alive on SEPTEMBER 17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donato A. Vargas Jr.		23B. DATE SIGNED 09/17/71		23C. PHYSICIAN'S NAME (Type) DONATO VARGAS, M.D.	
23D. ADDRESS BALTO, MD 21229		23E. ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-1971		24C. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	
24D. LOCATION Centreville, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert E. Taylor, R.D. 7	
24G. FUNERAL DIRECTOR Howard H. Hubbard		24H. ADDRESS 4107 Wilkens Ave. 21229			

ST. LOUIS, MO.

1917

ST. LOUIS, MO.

1917

ST. LOUIS, MO.

1917

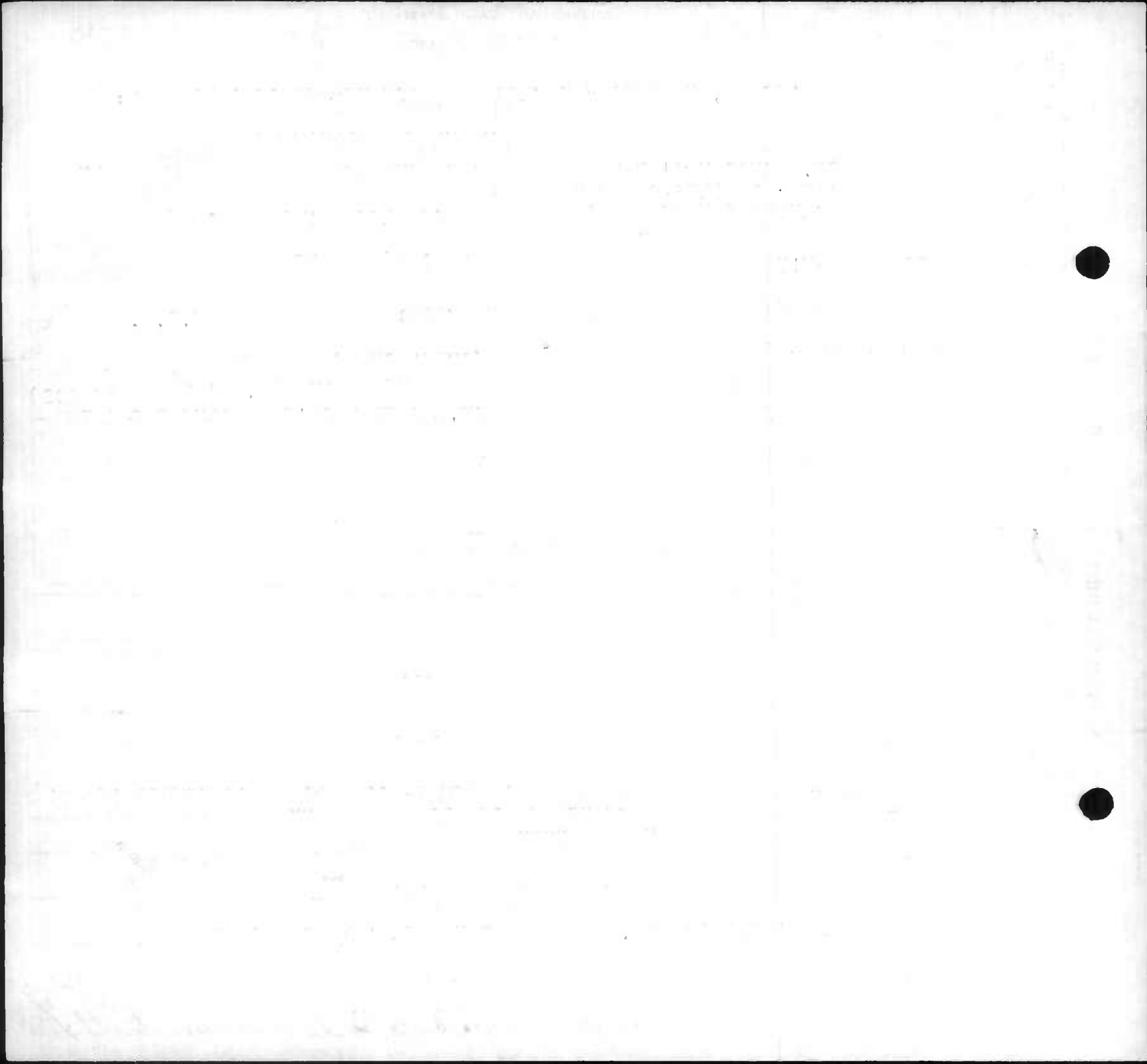
ST. LOUIS, MO.

ST. LOUIS, MO.

FUNERAL DIRECTOR: IMPORTANT

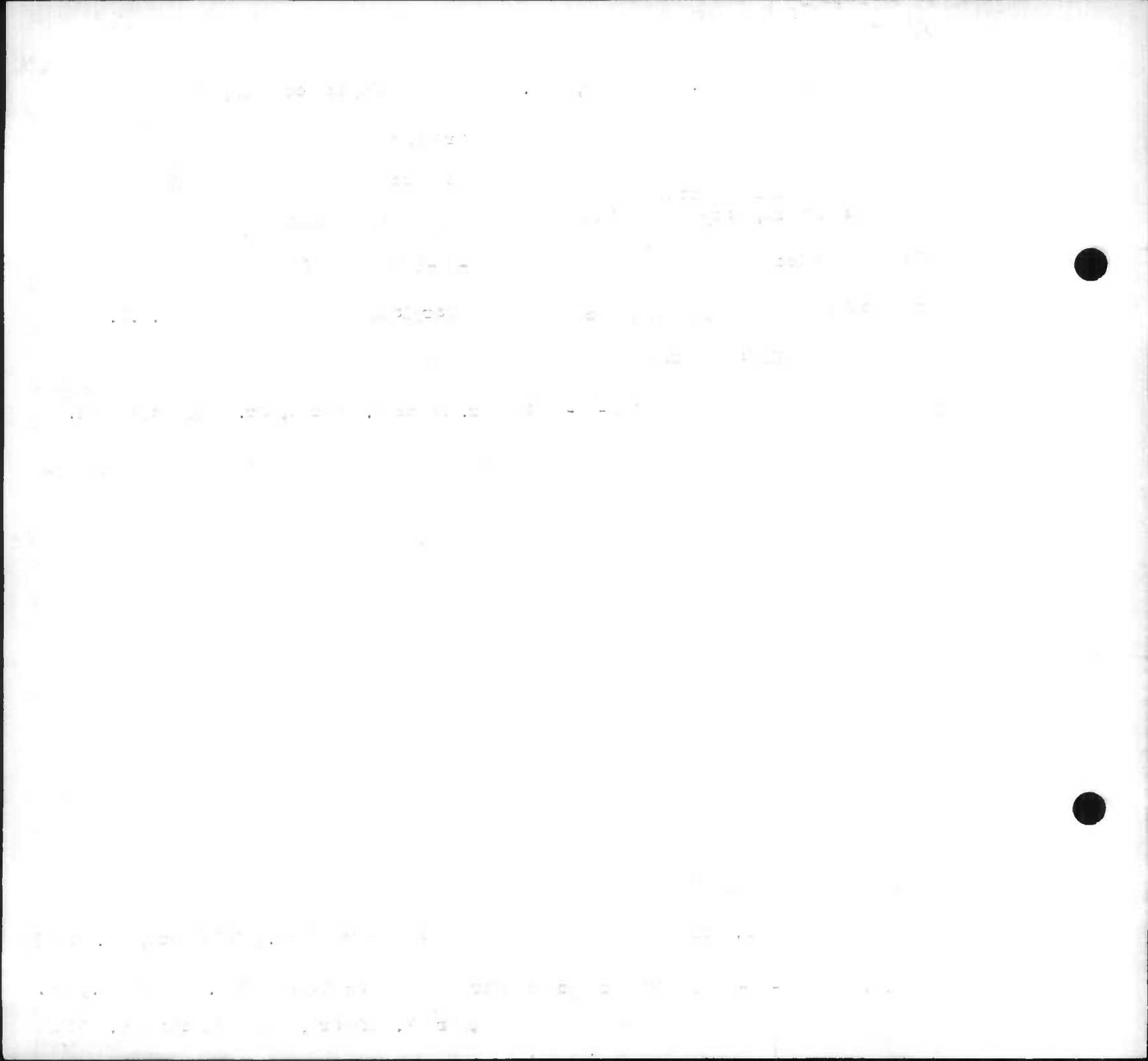
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 1.2em;">(U) - 253 71 8748</p> <p style="font-size: 1.2em;">BIRTH NO. 253 71 8748</p>		<p style="font-size: 1.2em;">CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;">CERTIFICATE OF DEATH</p>		<p style="font-size: 1.2em;">REG. NO. 71 8748</p>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
WIEGAND, KATHERINE TAYLOR			SEPTEMBER 15 1971 2:25A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229			MARYLAND BALTIMORE		
5. SEX			6. DATE OF BIRTH		9. AGE (In years last birthday)
FEMALE			02 01 96		75
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
HOUSE WIFE			HOME		MARYLAND
12. FATHER'S NAME			13. MOTHER'S MAIDEN NAME		
THOMAS ASHBY			(CUNNINGHAM) MARY		
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			15. SOCIAL SECURITY NO.		16. INFORMANT
NO					AVE BALTO MD. 21229 (RECORDS) ST. AGNES HOSPITAL WILKENS & CATON
17. CAUSE OF DEATH			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			8 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Cardiogenic shock		
			(B) RECENT HYPERTENSIVE INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		
			undetermined		
			(C) ASCVD		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (IX) (this hospital) attended the deceased from SEPTEMBER 13 19 71 to SEPTEMBER 15 19 71 that (IX) (we) last saw the deceased alive on SEPTEMBER 15 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Paulo Westphalen MD				9/15/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
PAULO WESTPHALEN MD.				CATON & WILKENS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
ENTOMBMENT		9/17/71		LOUDON PARK CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 20 1971		R. E. & J. B. MD		F. H.	



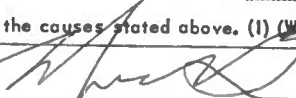
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

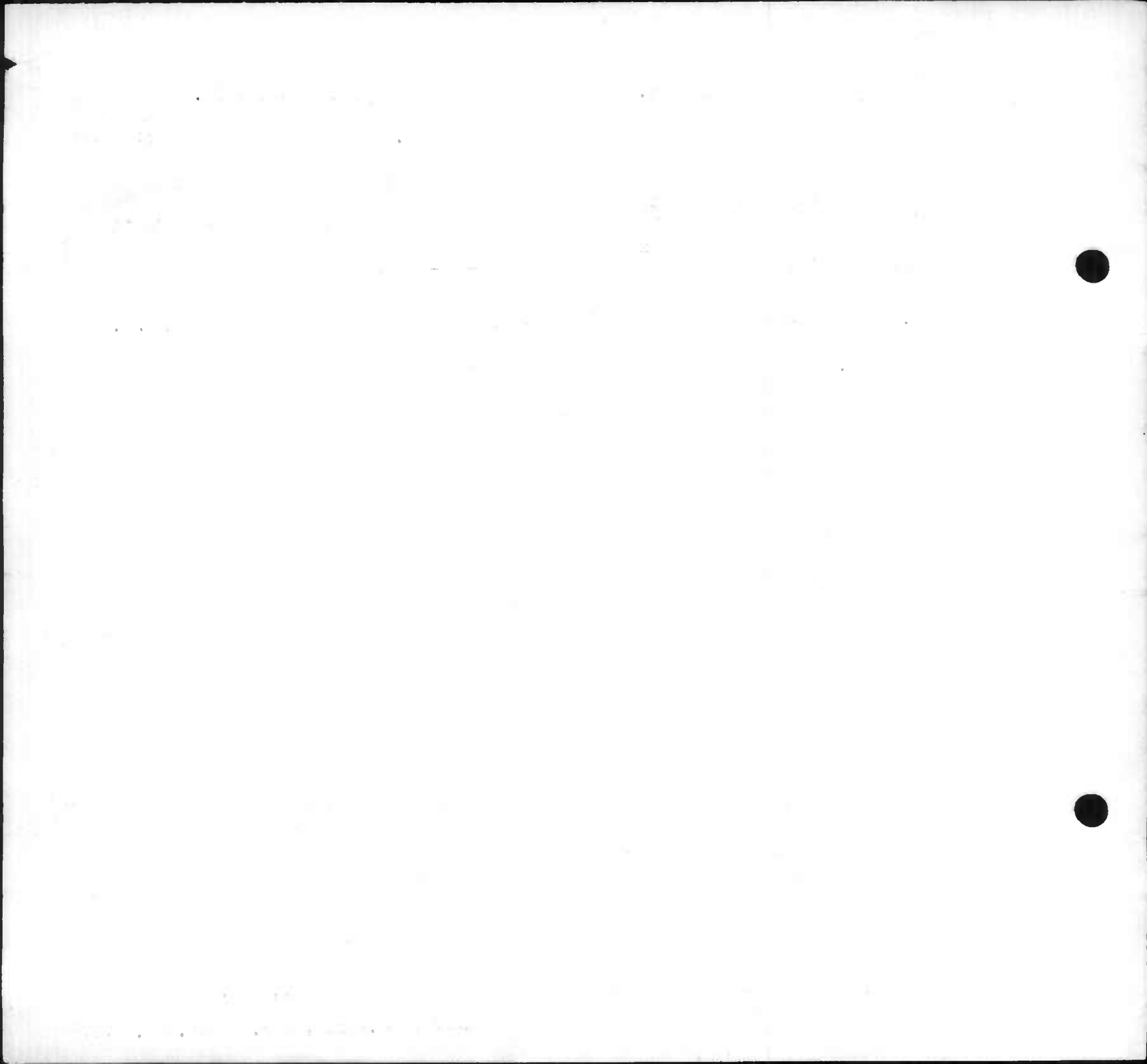
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8749	
BIRTH NO. M-560 71 8749				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JAMES K. MONROE, SR.			2. DATE AND HOUR OF DEATH September 17, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1615 Sexton Street Baltimore, Maryland 21230			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1615 Sexton Street		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1913	9. AGE (In years lost birthday) 58	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scrap Metal		10B. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John William Monroe			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-2072	17. INFORMANT ADDRESS Mr. James K. Monroe, Jr. 1615 Sexton St. 21230		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I. <i>Carcinoma right lung</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: II. <i>Metastasis to spine, brain</i> (B) DUE TO, OR AS A CONSEQUENCE OF: III. <i>4 months</i> (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 5-19 1971 to 9-17 1971 that (I) (we) lost saw the deceased alive on 9-16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE John P. Urlock, Jr. 23B. DATE SIGNED 9/17/71 23C. ADDRESS 1227 Washington Blvd., Baltimore, Md. 21230 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 9-20-1971 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery 24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co., Md. 25A. DATE REC'D BY HEALTH DEPT SEP 20 1971 25B. NAME OF REGISTRAR Howard M. Hubbard 25C. FUNERAL DIRECTOR ADDRESS Howard M. Hubbard, 4107 Wilkens Ave. 21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

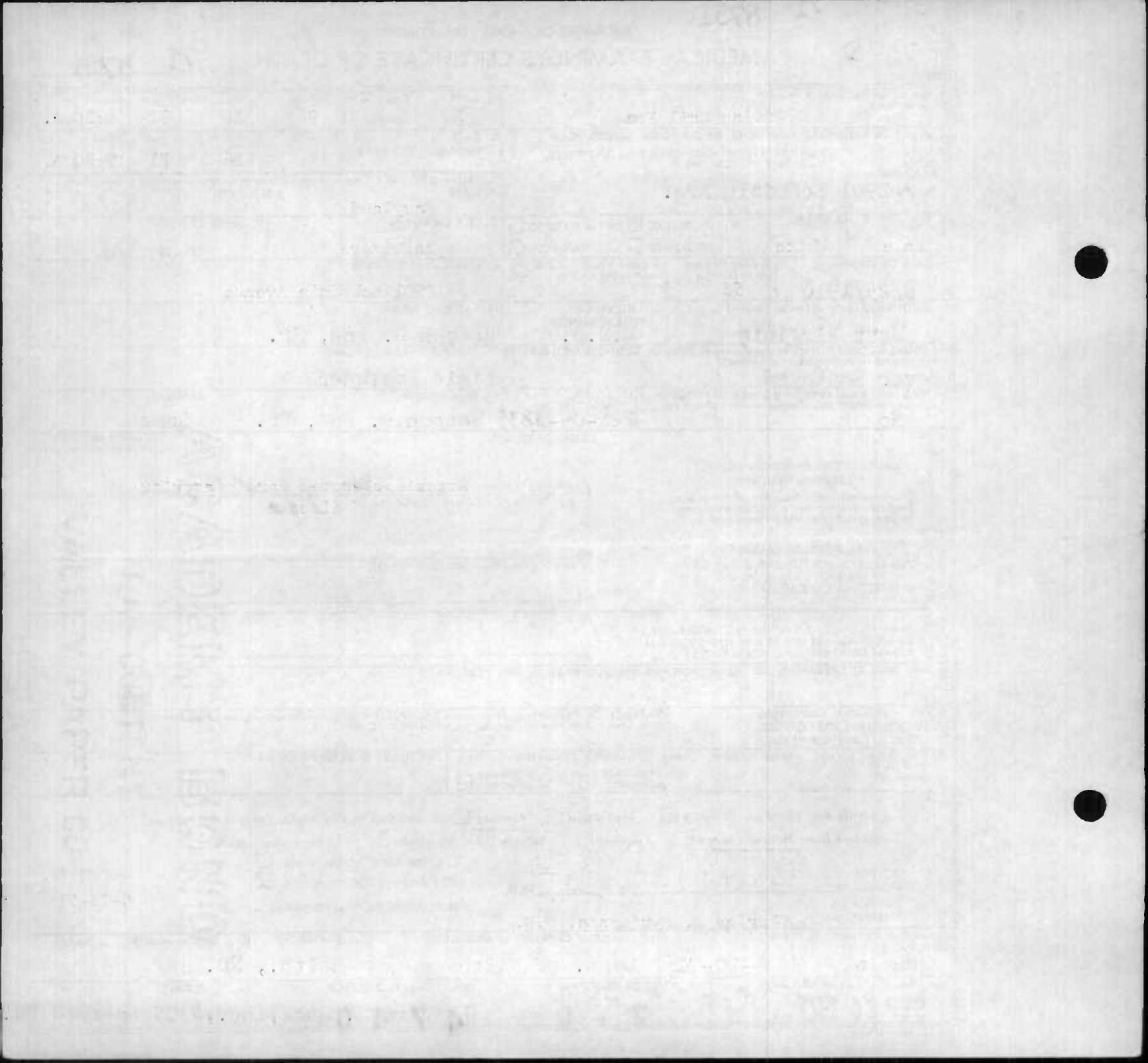
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				71 8750 REG. NO.	
7-52471 8750 BIRTH NO. 1. NAME OF DECEASED (Type or Print) WILLIAM Ralph FONSHELL		2. DATE AND HOUR OF DEATH September 16, 1971. 12.25 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1109 Homestead Street		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 905 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1109 Homestead Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1902	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Foreman-Supervisor C&P Telephone		10B. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Harry S. Fonshell		14. MOTHER'S MAIDEN NAME Mary Shilling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0427A		17. INFORMANT Florence Fonshell ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Immediate 16 years					
II MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 - - 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - - - 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - - -					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - -			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) - - -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - - -	
21F. HOW DID INJURY OCCUR? - - -		22. I certify that (I) (the hospital) attended the deceased from MARCH 26 1966 to AUG 27 1971 that (I) (we) last saw the deceased alive on AUG 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED SEP 14 / 71		23C. PHYSICIAN'S NAME (Type) EDW. J. BERSTOCK	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-71		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971 25B. NAME OF REGISTRAR Leonard J. Ruck 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 8751**

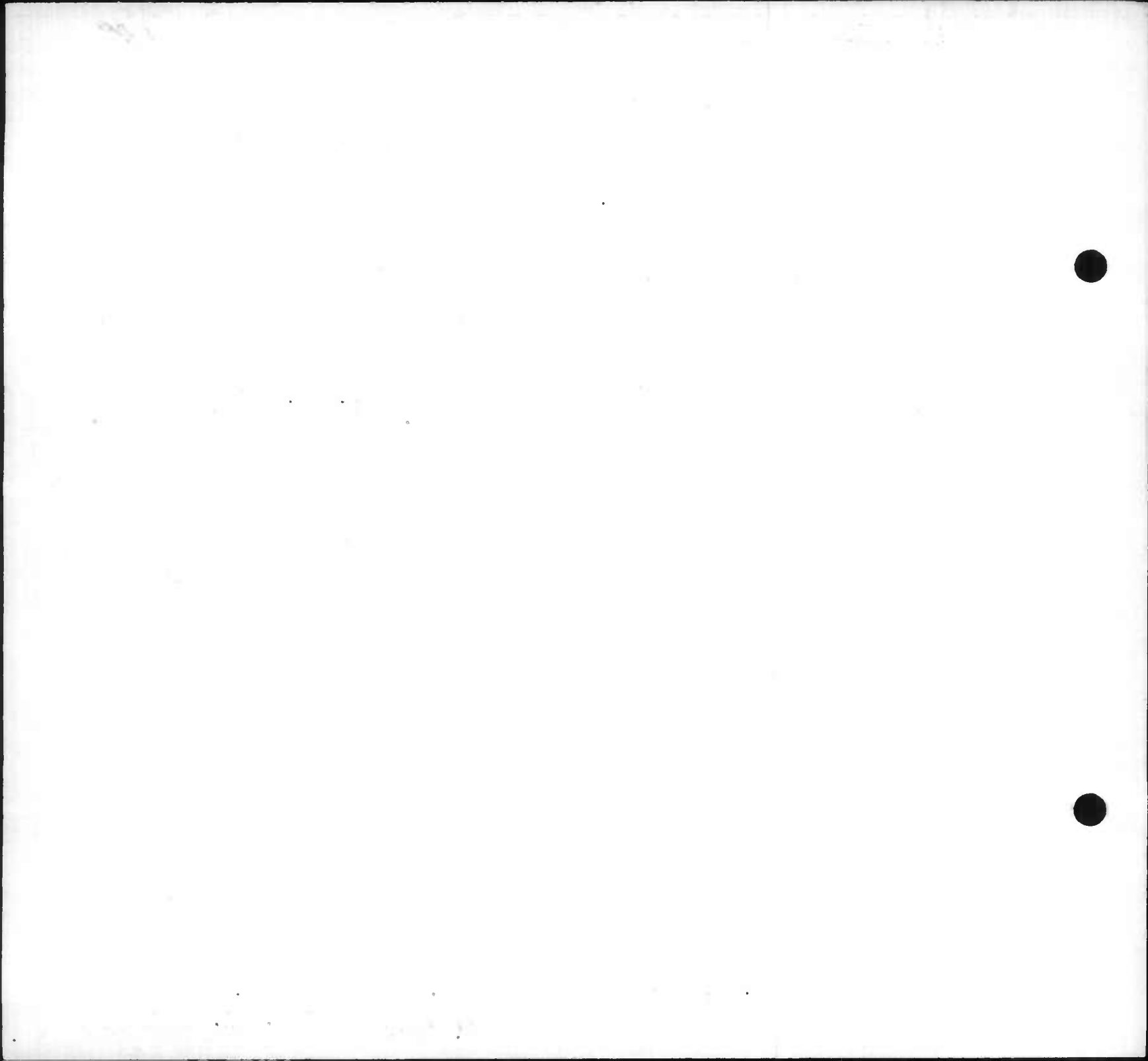
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Vivian Gail Poe		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 16 71 9:30 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2901 Echodale Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 16 71 9:30 A.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2733	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8/25/1916		10. AGE (In years lost birthday) 56		E. STREET AND NUMBER 2901 Echodale Avenue	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Watson B. Poe, Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Elsie Faulkner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 224-09-3235		18. INFORMANT Watson B. Poe, Sr.	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. AUTOPSY? (Yes or No) Yes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-16-71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-71		24C. NAME of CEMETERY or CREMATORY Gdns. of Faith	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971			
25B. NAME OF REGISTRAR Robert F. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8752</u>	
BIRTH NO. <u>B-452 71 8752</u>					
1. NAME OF DECEASED (Type or Print) <u>JOSEPH E. Bowling</u>		2. DATE AND HOUR OF DEATH <u>9/16/71 10:04 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1903</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1847 W. Lombard St.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/06</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian (Retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CHAMBER OF COMMERCE</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Richard Bowling</u>		14. MOTHER'S MAIDEN NAME <u>Emma Dowling</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-10-6362</u>		17. INFORMANT <u>Balto. Md. 21223</u> ADDRESS <u>Mary E. Riley 2536 Wilkens Ave.</u>	
18. <u>410.9 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Myocardial infarct, ant wall</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerotic Ht. disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>years</u>	
(C) <u>Pulmonary emphysema + bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>years</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8-29-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-29-71</u> 19 <u>71</u> to <u>9-16</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-16-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alvin W.D.</u>		23B. DATE SIGNED <u>9-16-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>MANUEL F. ARBUERNE</u>		23D. ADDRESS <u>7935 Pipers Park Rd Baltimore Md 21061</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept. 18, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Truman Schwab</u>	
ADDRESS <u>3512 Frederick Ave.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **71 8753**

1. NAME OF DECEASED
(Type or Print) **ESTELLA BEATRICE TONES**

2. DATE AND HOUR OF DEATH
9/15/71 9 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MD.** B. COUNTY **BALTO.**

5. CITY OR TOWN **Reisterstown** **D. INSIDE CITY LIMITS?** YES ☒ NO ☐

6. STREET AND NUMBER
56 BOND AVE.

7. SEX **F** **8. RACE** **Negro** **9. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

10. DATE OF BIRTH **8/10/87** **11. AGE (in years last birthday)** **84**

12. Under 1 Yr. Months: Days: Hours: Min. **13. Under 24 Hrs. Min.**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **RETIRED** **10B. KIND OF BUSINESS OR INDUSTRY**

11. BIRTHPLACE (State or foreign country) **Baltimore City** **12. CITIZEN OF WHAT COUNTRY?** **USA**

13. FATHER'S NAME **Nimrod Thompson** **14. MOTHER'S MAIDEN NAME** **Elsia Parker**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **No** **16. SOCIAL SECURITY NO.** **217-16-7407** **17. INFORMANT** **HOSPITAL CHART** **ADDRESS**

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE **RESPIRATORY ARREST** **14 Hours**
DUE TO, OR AS A CONSEQUENCE OF:

(B) CHRONIC LUNG DISEASE AND A.S.C.V.D. **MANY YEARS**
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY? (Yes or No)** **No** **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **While At Work** ☐ **Not While At Work** ☐ **21F. HOW DID INJURY OCCUR?**

22. I certify that (1) (this hospital) attended the deceased from 2 PM 9/15 19 71 to 9 PM 9/15 19 71 that (1) (we) last saw the deceased alive on 9/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE **W. P. MAGID M.D.** **23B. DATE SIGNED** **9/15/71**

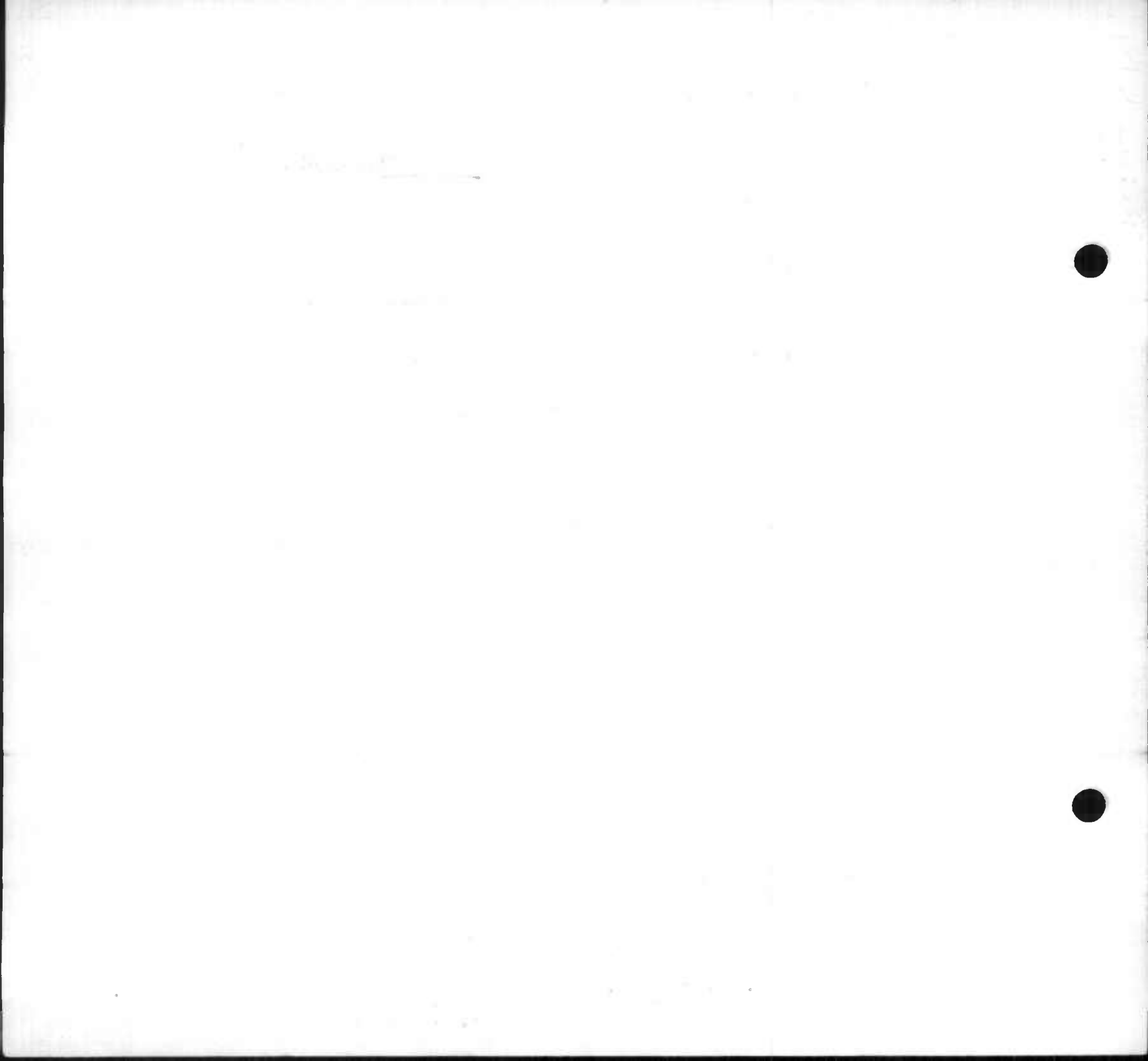
23C. PHYSICIAN'S NAME (Type) **W. P. MAGID M.D.** **23D. ADDRESS** **UNIVERSITY HOSPITAL, BALTO, MD**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** **24B. DATE** **Sept. 18, 71** **24C. NAME OF CEMETERY or CREMATORY** **St. Lukes Cemetery** **24D. LOCATION** **Reisterstown, Md.**

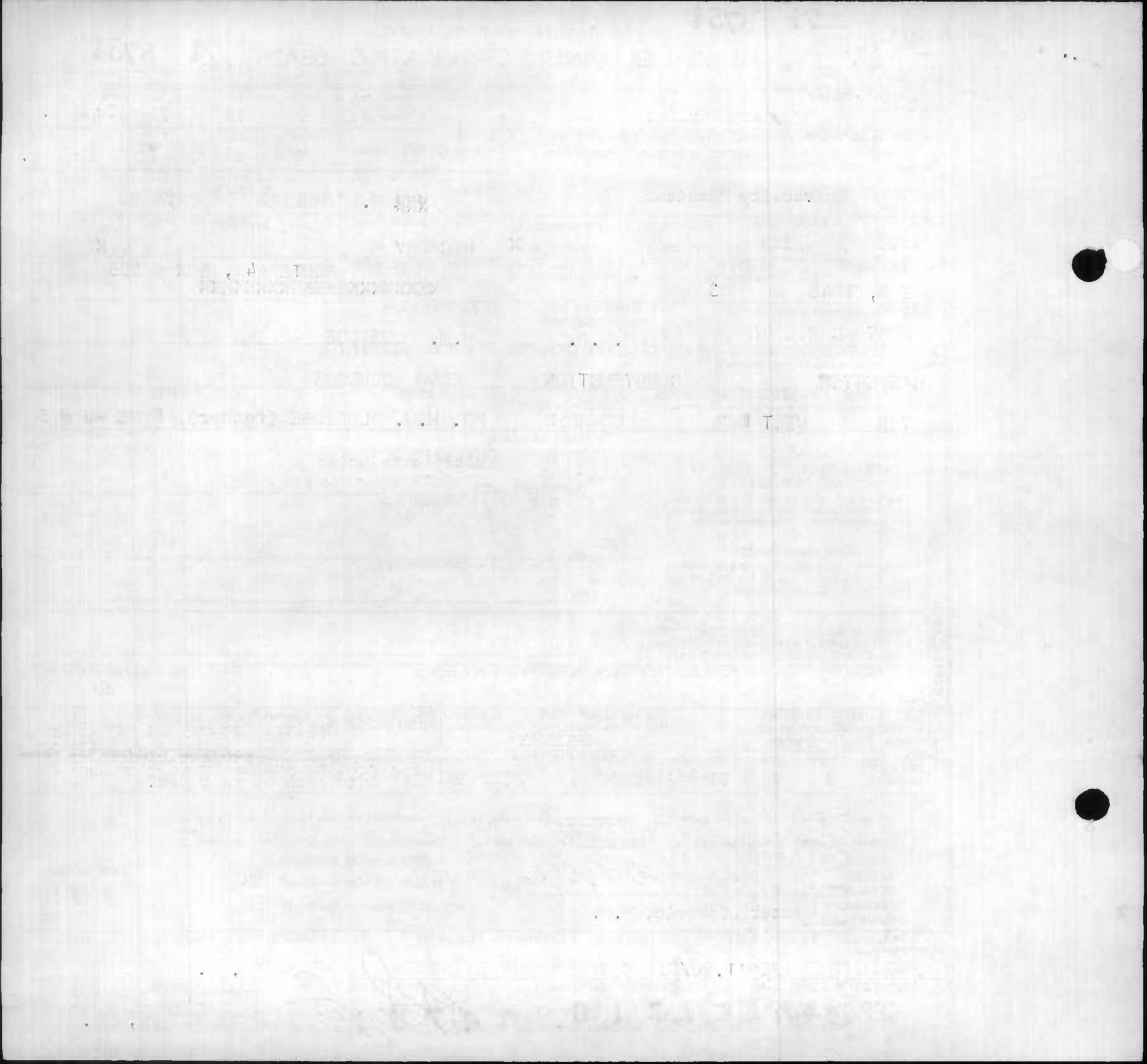
25A. DATE REC'D BY HEALTH DEPT. **SEP 20 1971** **25B. NAME OF REGISTRAR** **Rob E. Bailey, Md.** **25C. FUNERAL DIRECTOR** **Elaine Funeral Home Reisterstown Md**

VS 150-REV. 1/1/68

Released By: MED



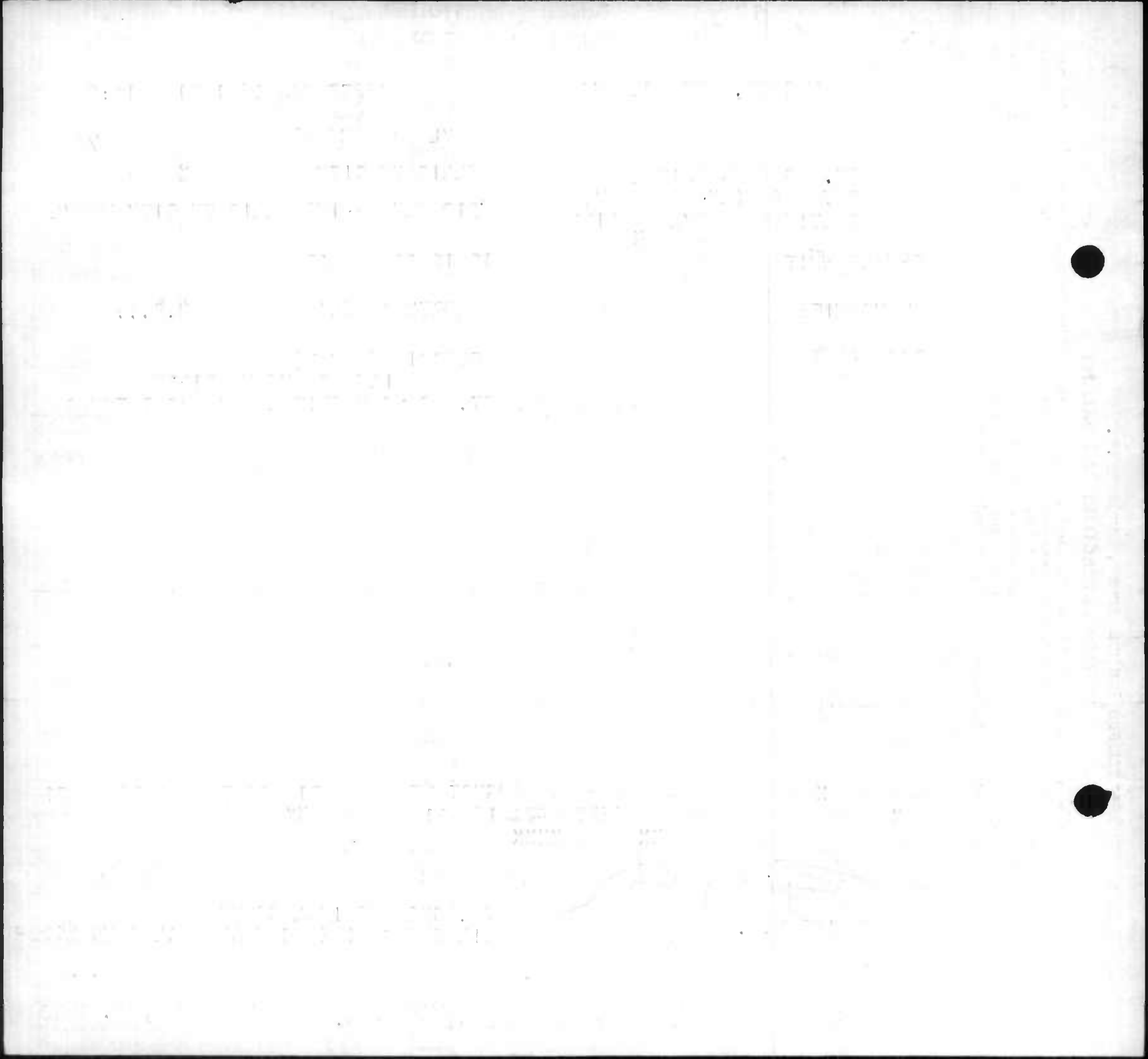
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 8754	
1. NAME OF DECEASED (Type or Print)		Thomas Aldridge		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year Hour	
38 University Hospital				9 16 71		5:50 a.m.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
male		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		A. STATE N.C. N. CAROLINA B. COUNTY CATAWBA	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
JUNE 8, 1948		23		NORTH CAROLINA		U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
CARPENTER		CONSTRUCTION		EDNA JOHNSON		YES VIET NAM	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
UNKNOWN		MR. H.W. ALORIOGE (father)		Multiple injuries		21. AUTOPSY? (Yes or No)	
		SAME AS # 5		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		no	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
		HIGHWAY		Capital Raceway on Hwy 301-Exit		7 7 71 12:15 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?		Subject riding on rear of car being pushed by another car - fell into path of rear car.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
ACTUAL SIGNATURE		BURIAL		SEP'T. 20/71		CATAWBA MEMORIAL PARK	
EXAMINER'S NAME (Type)		Peter Lipkovic, M.D.		24D. LOCATION (City, town, or county)		HICKORY, N. CAROLINA	
				25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
				SEP 20 1971		25C. FUNERAL DIRECTOR	
						SINGLETON FUNERAL HOME	
						GLEN BURNIE, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

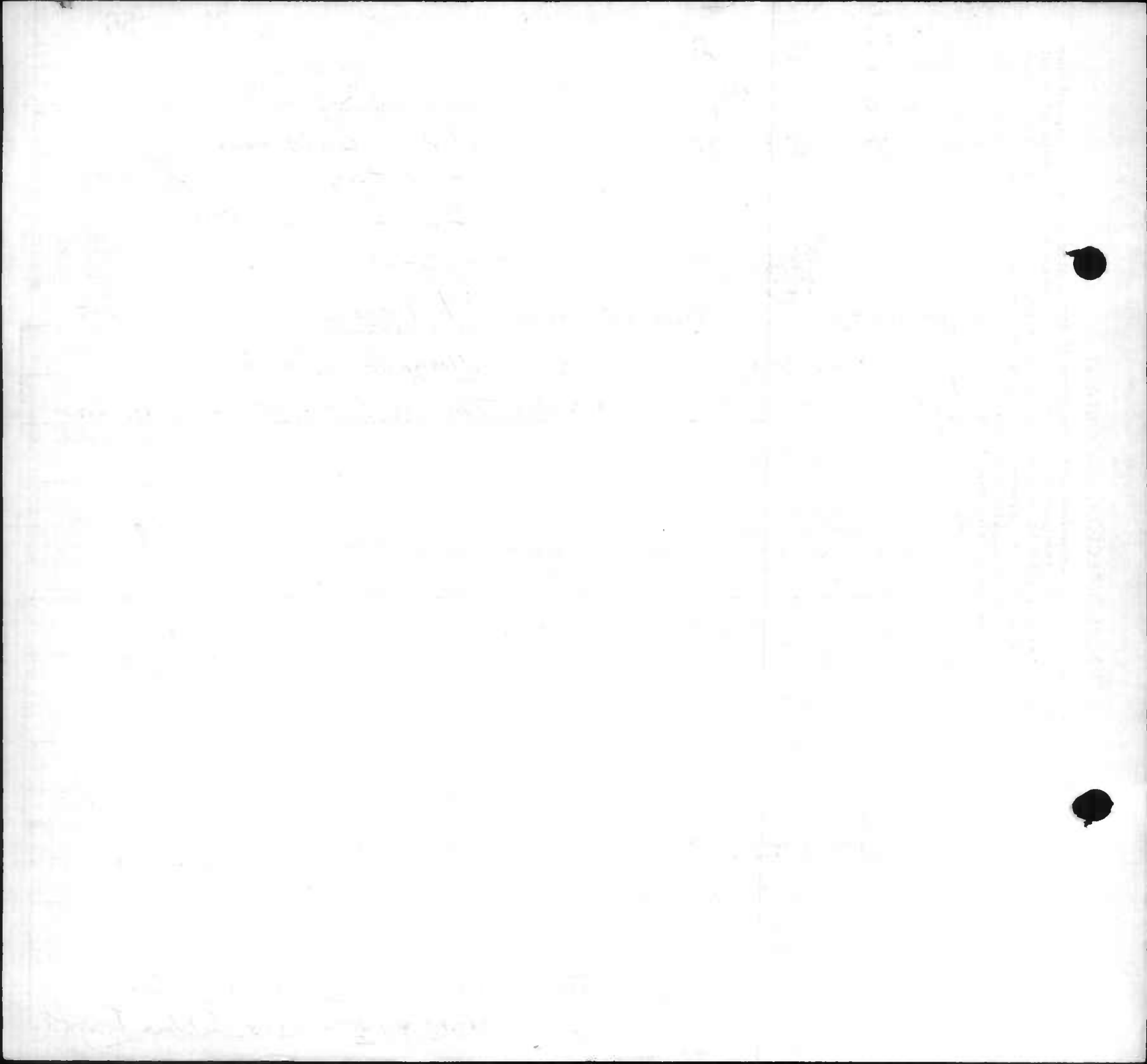
BIRTH NO. <u>H-230 71 8755</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 8755</u>	
1. NAME OF DECEASED (Type or Print) <u>HOCUTT, ETTA GLADYS</u>				2. DATE AND HOUR OF DEATH <u>SEPTEMBER 16 1971 10:00A M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUE</u> <u>BALTIMORE MARYLAND 21229</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>ELLICOTT CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 12 33</u>	
9. AGE (In years last birthday) <u>37</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED BANE</u>				14. MOTHER'S MAIDEN NAME <u>FLOSSIE (RAGAN)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>239-46-4353</u>		17. INFORMANT <u>WILKENS AVENUE 21229</u> <u>ST. AGNES HOSPITAL RECORDS CATON &</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>020X I</u> <u>CAUSE OF DEATH</u> <u>Infectious Hepatitis</u> <u>4 weeks</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 27</u> 19 <u>71</u> to <u>SEPTEMBER 16</u> 19 <u>71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPTEMBER 16</u> 19 <u>71</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED <u>9/15/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>R UPDIKE, M.D.</u> DEGREE				23D. ADDRESS <u>ST. AGNES MEDICAL CENTER</u> <u>WILKENS & PINE HGTS AVE BALTO MD 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/18/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Restlawn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Durham N.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Black Ellicott City, Md. 21043</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

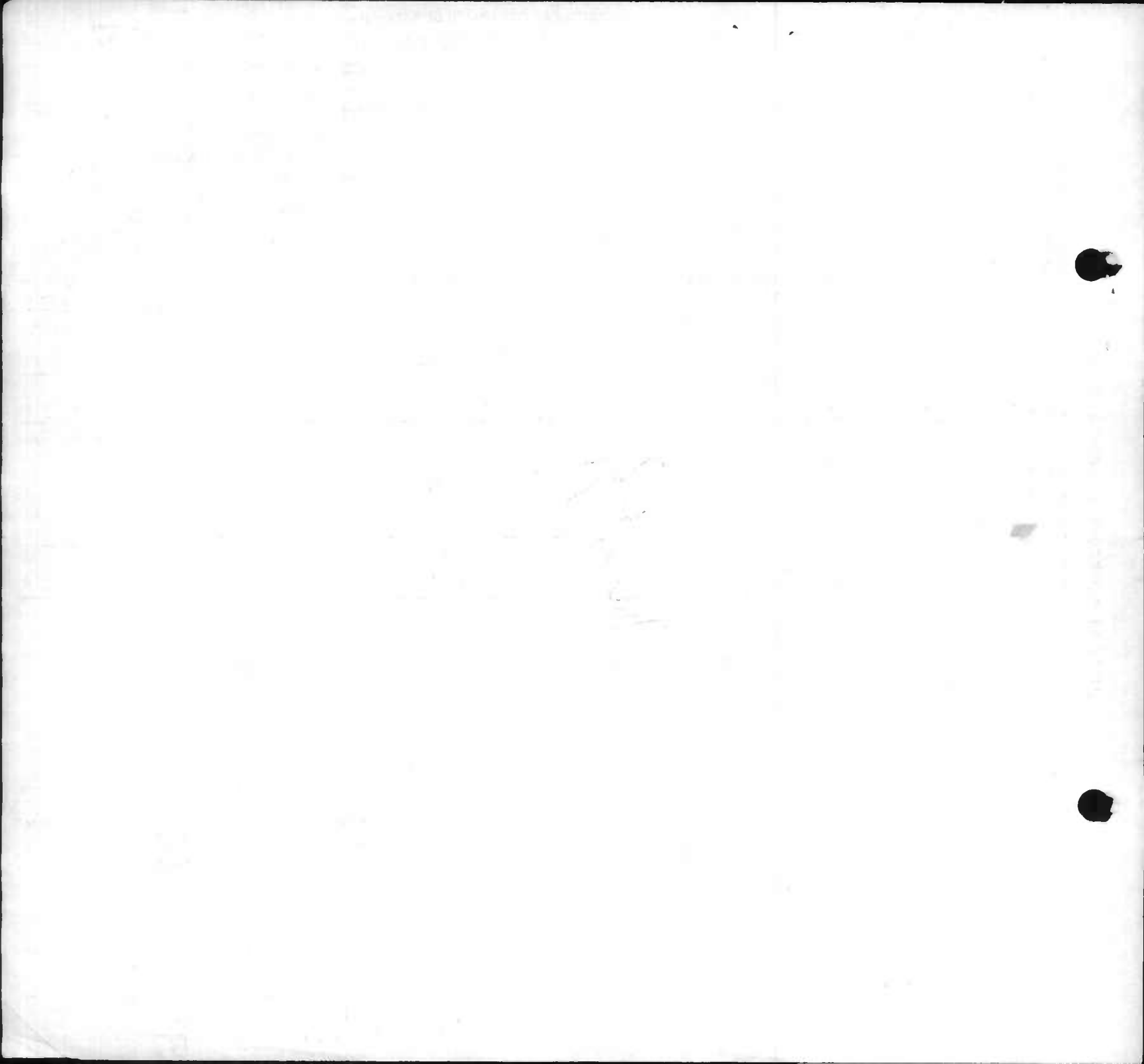
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8756	
C-245 71 8756		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PHILIP W. CASILAN		2. DATE AND HOUR OF DEATH SEPT-16, 1971 1:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5505 Osage Ave.			
5. SEX MALE	6. RACE Yellow	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-23-01	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) PHILIPPINE ISLANDS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nino Casilan		14. MOTHER'S MAIDEN NAME MANUELLA SANJOSE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 075-12-1188		17. INFORMANT Theodore Victor 5505 Osage Ave.	
18. 2509 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) IMPENDING STROKE OR CVA II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.A.	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N.A.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N.A.	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 4 1971 to SEPT. 15 1971 that (I) (we) last saw the deceased alive on SEPT. 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson R. De Lara, M.D.		23B. DATE SIGNED 9-16-71		23C. PHYSICIAN'S NAME (Type) NELSON R. DE LARA	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. FUNERAL DIRECTOR ADDRESS		24F. DATE REC'D BY HEALTH DEPT. SEP 20 1971	
24G. NAME of REGISTRAR		24H. NAME of REGISTRAR		24I. NAME of REGISTRAR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 71 8757				CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8757	
1. NAME OF DECEASED (Type or Print) HYLLA, EMIL				2. DATE AND HOUR OF DEATH 9/15/71 2:30 pm			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital, Baltimore 44 Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN Cockeysville, Md D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 223 HIGHMEADOW RD.			
5. SEX male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4/19/90	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - CARPENTER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HYLLA, John			
14. MOTHER'S MAIDEN NAME PAULINE UNKNOWN RUDOLPH				15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown NO			
16. SOCIAL SECURITY NO. 24-27-2313				17. INFORMANT ADDRESS Mr. MARONIC Home Cockeysville, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Comminuted fx (L) shoulder & Pelvis Senility				19. CAUSE OF DEATH A. IMMEDIATE CAUSE B. DUE TO, OR AS A CONSEQUENCE OF: C. Senility			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. DATE OF OPERATION None		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) No		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Masonic Homes		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Masonic Homes, Cockeysville 5300		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 9 3 71	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Commanding General fell from window					
22. I certify that (I) (this hospital) attended the deceased from 3/9/71 to 15/71 and that (I) (we) last saw the deceased alive on 15/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Atkins M.D.				23B. DATE SIGNED 9/15/71		23C. PHYSICIAN'S NAME (Type) LOUIS S. ELIAS	
23D. ADDRESS Union Memorial Hospital, Baltimore				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 9-18-71				24C. NAME OF CEMETERY OR CREMATORY LODOW PARK CEMETERY			
24D. LOCATION BALTIMORE, MARYLAND				25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971			
25B. NAME OF REGISTRAR Robert E. Barber, R.D.				25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Inc. Md.			



H-325 71

8758

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8758

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ANNA THERESA HUTSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

September 14, 1971

5:35 P.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

602

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11/20/11

10. AGE (In years
last birthday)

59

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

138 N. Kenwood Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lambert C. Davis

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

14B. KIND OF BUSINESS OR INDUSTRY

at home

15. MOTHER'S MAIDEN NAME

Anna Franke

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

216-32-5289

18. INFORMANT

ADDRESS

Wm. Hutson (husband) same address as above

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Intracerebral Hemorrhage

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/15/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/18/71

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

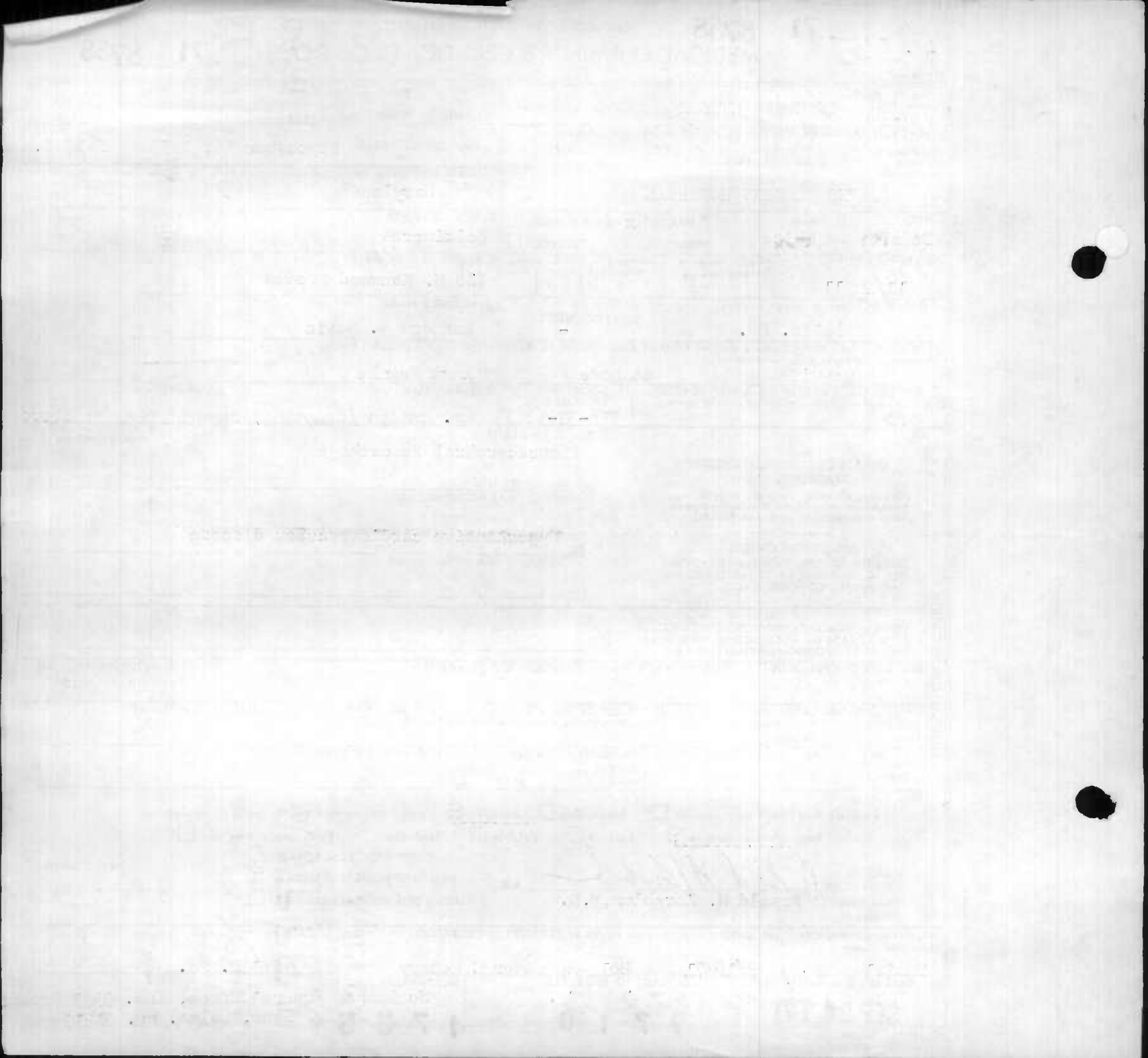
25C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1971

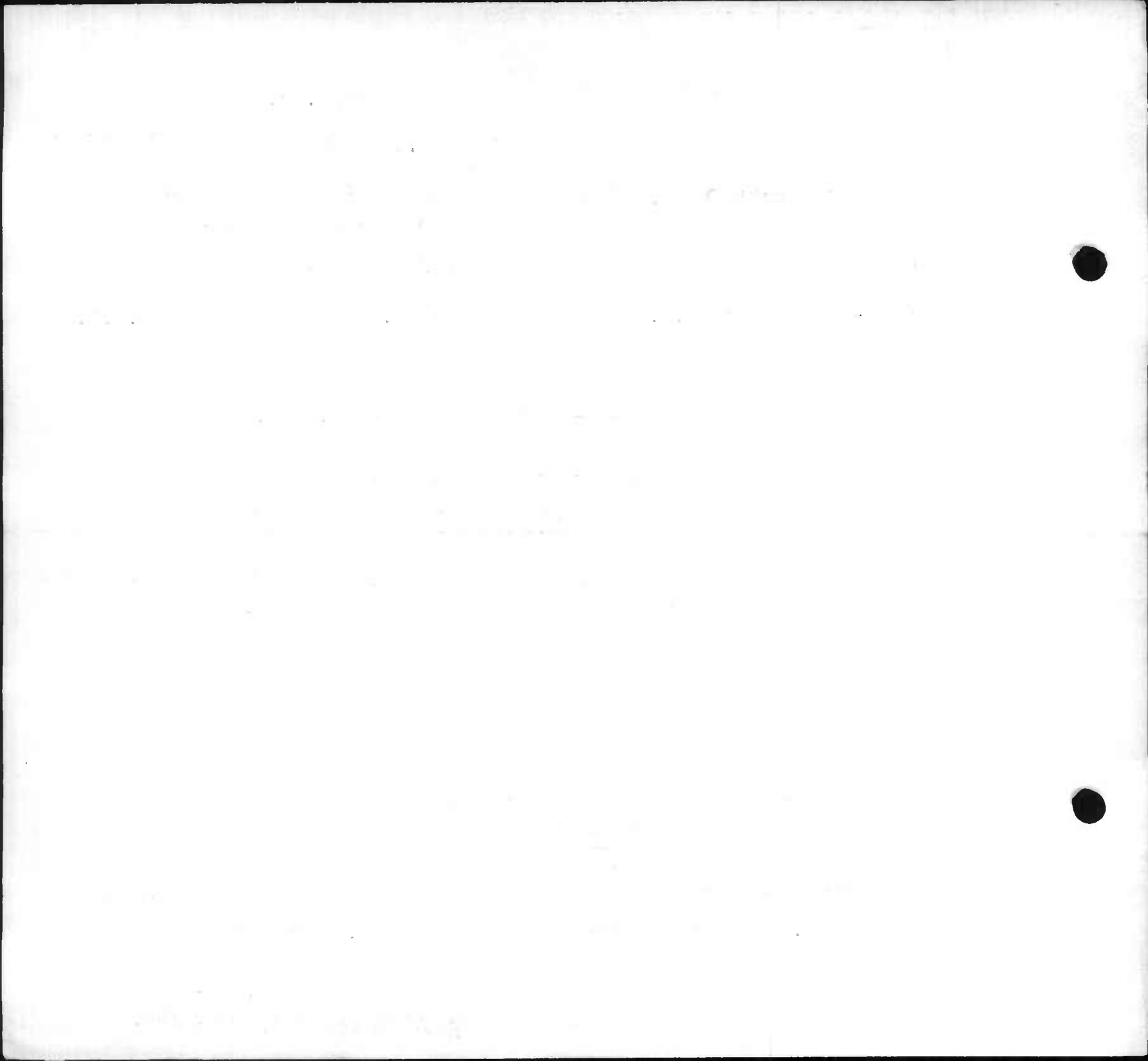
Robert E. Farber, M.D.

Schimunek Funeral Homes, Inc. 3331 Brehms
Lane, Balto. Md. 21213



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8759	
BIRTH NO. B-650 71 8759		1. NAME OF DECEASED (Type or Print) HAROLD GEORGE BRAUN		2. DATE AND HOUR OF DEATH Sept. 13, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5094 Orville Ave. 21205			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md., 21205 B. COUNTY 2653 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5094 Orville Avenue		
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1900	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Postmaster		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Albert Braun			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 163-05-8677		17. INFORMANT Edward Braun, son, above	
18. CAUSE OF DEATH 153.81 4 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <i>cachexia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>metastatic Ca of liver</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Ca of colon - diabetes.</i> (C) <i>Diabetes, mild; prostatectomy</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). status post prostatectomy					
19A. DATE OF OPERATION 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of colon		20A. AUTOPSY? (Yes or No) no.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 19 to 9/10/71 19 71 that (I) (we) last saw the deceased alive on 9/9/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Theodore J. Graziano		23B. DATE SIGNED 9/14/71		23C. PHYSICIAN'S NAME (Type) Dr. Theodore Graziano	
23D. ADDRESS 1654 E. Belvedere Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/16/71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
25D. ADDRESS 8331 Brehms Lane					



BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8760			
C-455 71 8760 MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Francis C. Coleman				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 14 71 8:15 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 14 71 8:15 A. M.			
6. SEX Female				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1102			
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Oct. 22, 1931		10. AGE (In years last birthday) 39		E. STREET AND NUMBER 18 E. Preston St. Apt. 4			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nelson Weedon Coleman			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		14B. KIND OF BUSINESS OR INDUSTRY Restaurant		15. MOTHER'S MAIDEN NAME Catherine Elizabeth Anderson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-30-3513		18. INFORMANT mother Mrs. Catherine E. Coleman, Centerville, Md.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Unidentified drug overdose (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Contributing: (b) Acute alcoholic intoxication DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 18 E. Preston Street			
22D. TIME OF INJURY (APPROX.) 9 14 71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? ingested drugs Apparently drank alcoholic beverages &			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 9-14-71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 17, 1971		24C. NAME OF CEMETERY or CREMATORY Church Hill Cemetery		24D. LOCATION (City, town, or county) (State) Church Hill, Q.A. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Galen, M.D.		25C. FUNERAL DIRECTOR James H. Bartsch		ADDRESS Bartsch Bros., Centerville, Md.	

ACADITORY

VALLEY PAPER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8761	
G-43071 8761					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) ANNA GOLD			2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1971 9:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7010 SURREY DRIVE, 2nd FLOOR			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 7010 SURREY DRIVE, 2nd FLOOR		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-1895	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM GOLDBERG			
14. MOTHER'S MAIDEN NAME FANNIE GOLDBERG		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT MR. SAMUEL MILLER, 7010 SURREY DR., 1st. FLOOR			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 470.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension + Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF: acute years					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1965 to 9/15/71 19 71 that (I) (we) last saw the deceased alive on 9/15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis R. Maser M.D.		23B. DATE SIGNED 9/16/71		23C. PHYSICIAN'S NAME (Type) LOUIS MASER	
23D. ADDRESS 2724 SMITH AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 9-17-71		24C. NAME OF CEMETERY OR CREMATORY MIKRO KODESH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR John S. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

1

71 8762

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8762

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) (EDWARD) EDDIE MANNING		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Sept. 17, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour Sept. 17, 1971 3:55 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 704	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 800 N. Washington St.	
9. DATE OF BIRTH 2-12-1912		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Garfield Manning		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Clara		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 246-03-2768		18. INFORMANT Mrs. Jessie Brown Fayetteville, N.C.	
19. 39571 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Aortic stenosis and insufficiency (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic cardiovascular disease	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Sprigate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Sprigate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9-18-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Fayetteville, N.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	

1950

RECEIVED

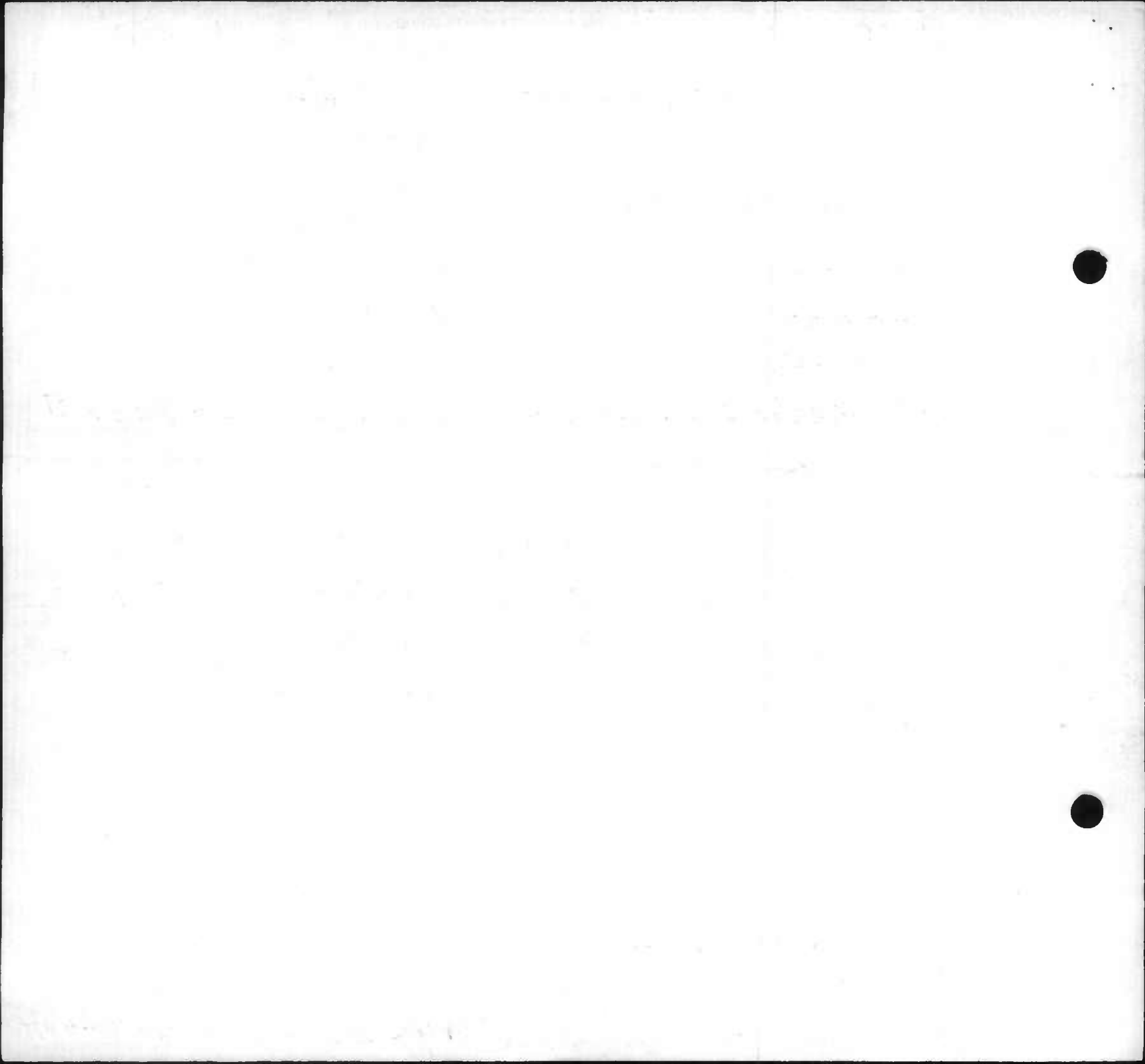
1950

ACADEMIC DEPT

1950

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-524 71 8763		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8763	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CONIGLAND, James LEE		9/16/71 245 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		1002	
The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 939 Abbott Court			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negro		9/9/06	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER				N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Conigland		Manerva Joseph			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 12/27/43-5/15/45		218-03-4117		DORIS CONIGLAND 2514 Francis Pt	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		36 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bleeding Diathesis 2 nd to Documented April 2 DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Intravascular Coagulation 2 nd to Melancholia years Presumably Coronary Hypertension; ASCVD, Anemia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		Yes		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 3 1971 to Sept 16 1971 that (I) (we) lost saw the deceased alive on Sept 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Varnell, Jr., M.D.		9/16/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. Varnell, Jr., M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	9/21/71	Mt. Calvary	Q. A. Counts, Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
SEP 20 1971	Rebecca L. ...	Joseph B. ...		1304 ...	



CERTIFICATE OF DEATH

REG. NO. 71 8764

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAMS, MARY

2. DATE AND HOUR OF DEATH

SEP 17, 1971 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION31 BALTIMORE CITY HOSP.
4940 Eastern Avenue
BALTIMORE, MD. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1611 Gwynns Falls Parkway

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

1-18-28

9. AGE (In years
last birthday)

43

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

Baltimore, Md

13. FATHER'S NAME

Oliver Parsons

14. MOTHER'S MAIDEN NAME

Hattie Shavers

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH: Records 4940 Eastern Avenue
Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Hepatic failure
CirrhosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5-6 yrs

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Chronic Pancreatitis, G-I Bleeding
Chronic alcoholism

5-6 yrs.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Anemia

5-6 yrs.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

21. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/26 19 71 to 9/17 19 71
that (I) (we) last saw the deceased alive on 9/17 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Surat Sinasa M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Sep. 17, 1971

23C. PHYSICIAN'S
NAME (Type)

SURAT SINASA, M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/22/71

24C. NAME OF CEMETERY OR CREMATORY

Arbiter Memorial Park

24D. LOCATION

Arbiter Memorial Park

City, town, or county

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1971

25B. NAME OF REGISTRAR

Barbara E. Taylor, R.D.

25C. FUNERAL DIRECTOR

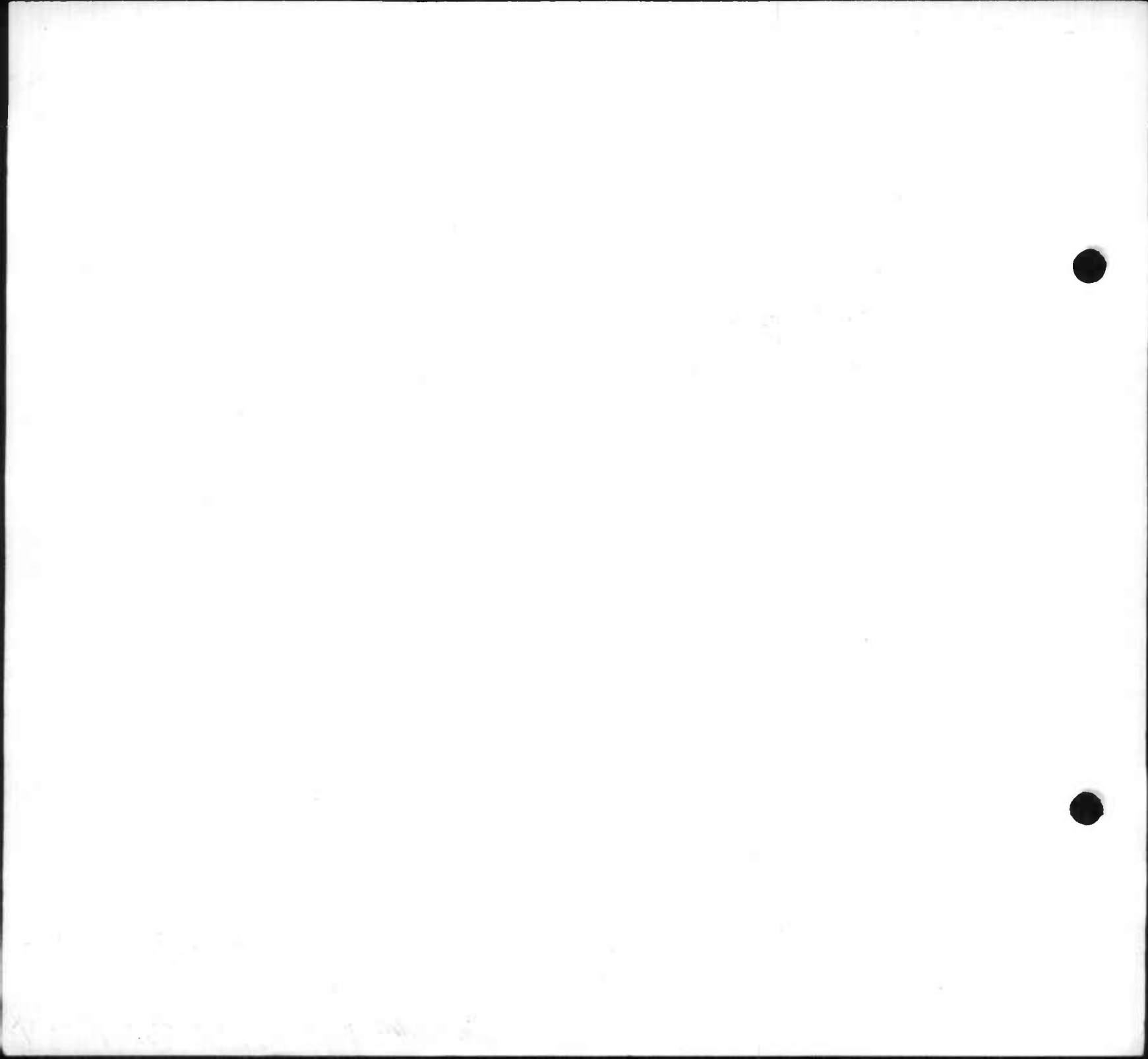
Williams Funeral Home

ADDRESS

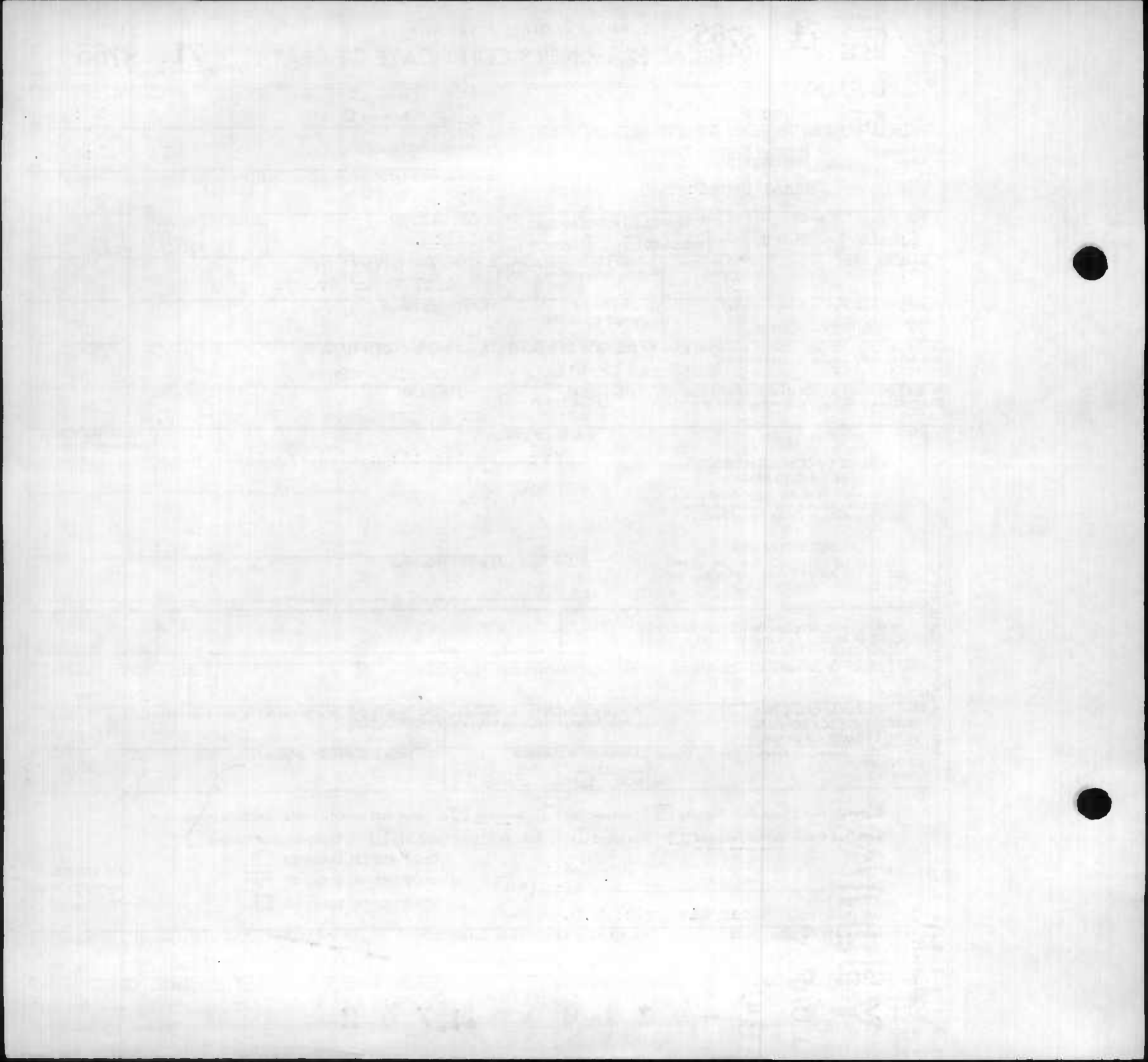
3197 Howard St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



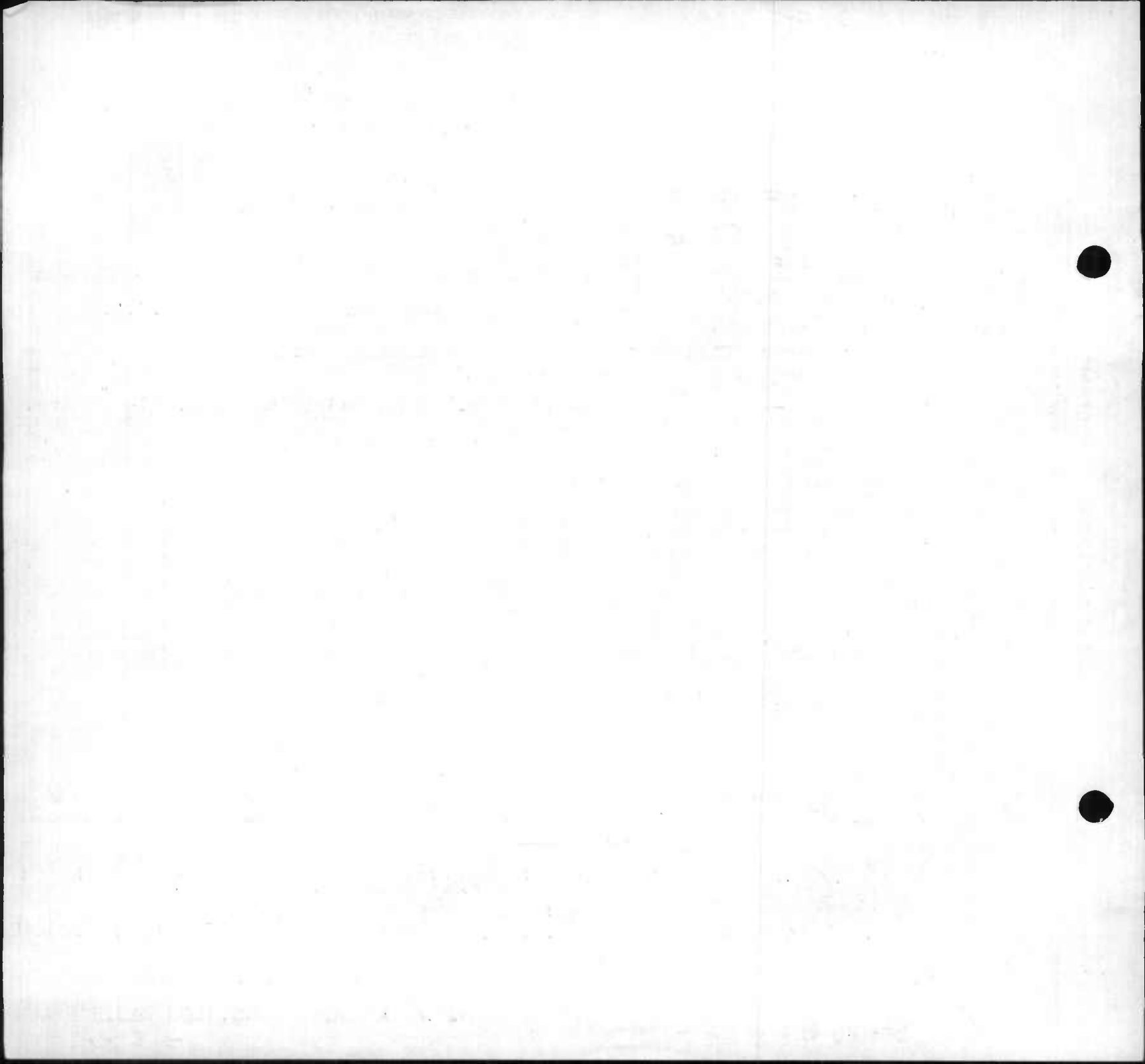
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-42071		8765		71 8765	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
Rose Wells		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
		9 16 71		11:20 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		6. SEX	
Sinai Hospital		A. STATE Md. B. COUNTY 2716		female	
7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH	
Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday)	
				53	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF		13. FATHER'S NAME	
Bridgeport, Conn.		U.S.A.		unk.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
Ward Clerk		Lutheran Hospital		Elizabeth Hyman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
no		215-16-0324		Mr. Robert Jones 4527 Homer Ave. 21215	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
2				yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		9/17/71	
Peter Lipkovic, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		9-21-71		Aubutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 20 1971				135 Harford Ave. 21213	
				Marshall W. Jones, Jr.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

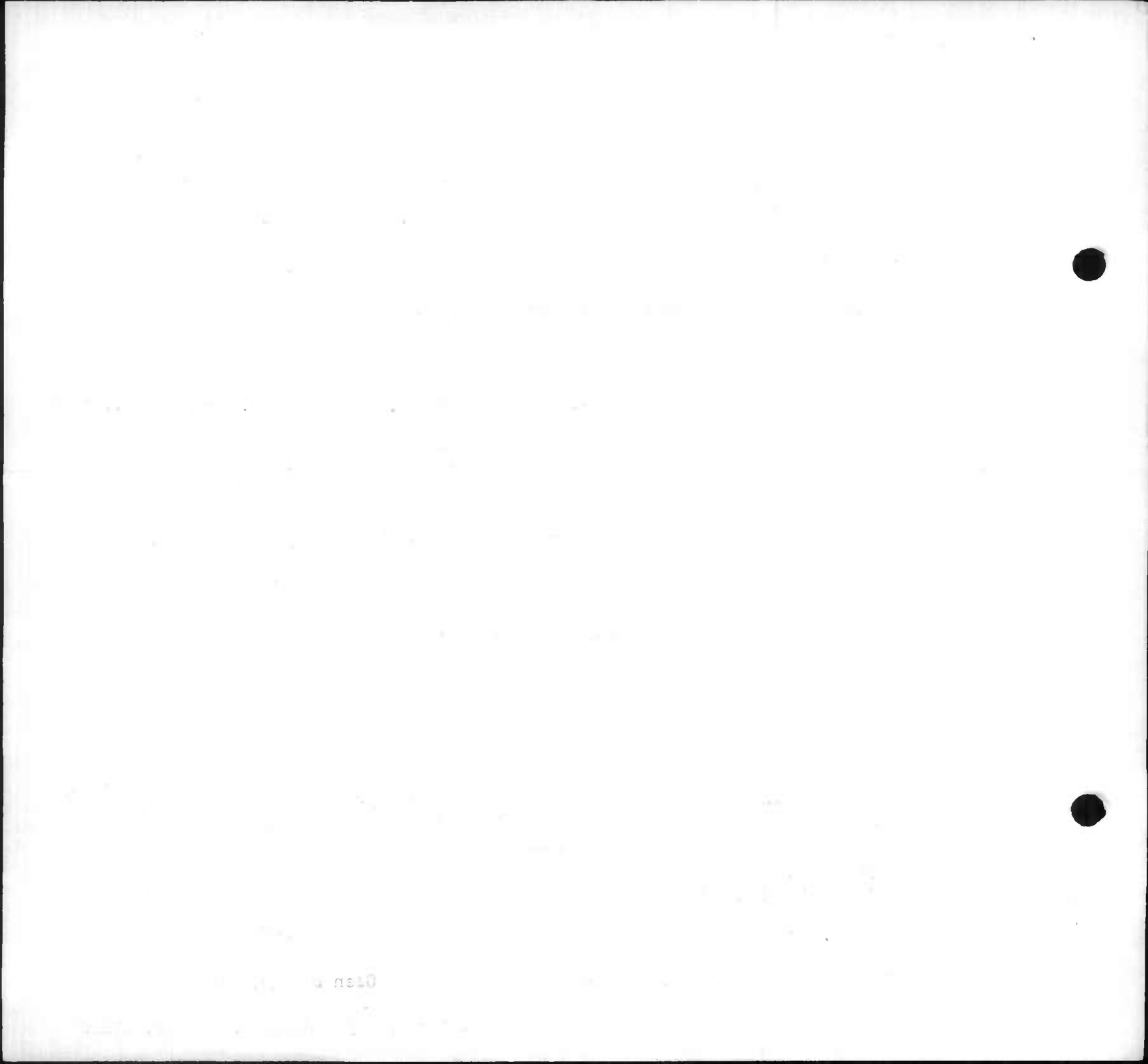
<div style="display: flex; justify-content: space-between;"> R-325 71 8766 CERTIFICATE OF DEATH REG. NO. 71 8766 </div>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CZESLAWA RADZIMINSKI		2. DATE AND HOUR OF DEATH 9/7/71 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5712 Fenwick Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3029 Eastern Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/98
9. AGE (In years last birthday) 73		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Seweryn Kisielewski		14. MOTHER'S MAIDEN NAME Stefania Malanowski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 218-12-4116D	
17. INFORMANT Mr. Stefan Radzinski, Jr.		ADDRESS 319 S. Ellwood Ave.	
18. 348.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myotrophic Lateral Sclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 19 71 to September 17 19 71 , that (I) (we) last saw the deceased alive on September 13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE A. Allan Spier MD		23B. DATE SIGNED 9/7/71	
23C. PHYSICIAN'S NAME (Type) A. Allan Spier		23D. ADDRESS M.D. 1501 Pentridge Road, Baltimore, Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/71	
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR J. E. Sadowski	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS		ADDRESS 1808 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

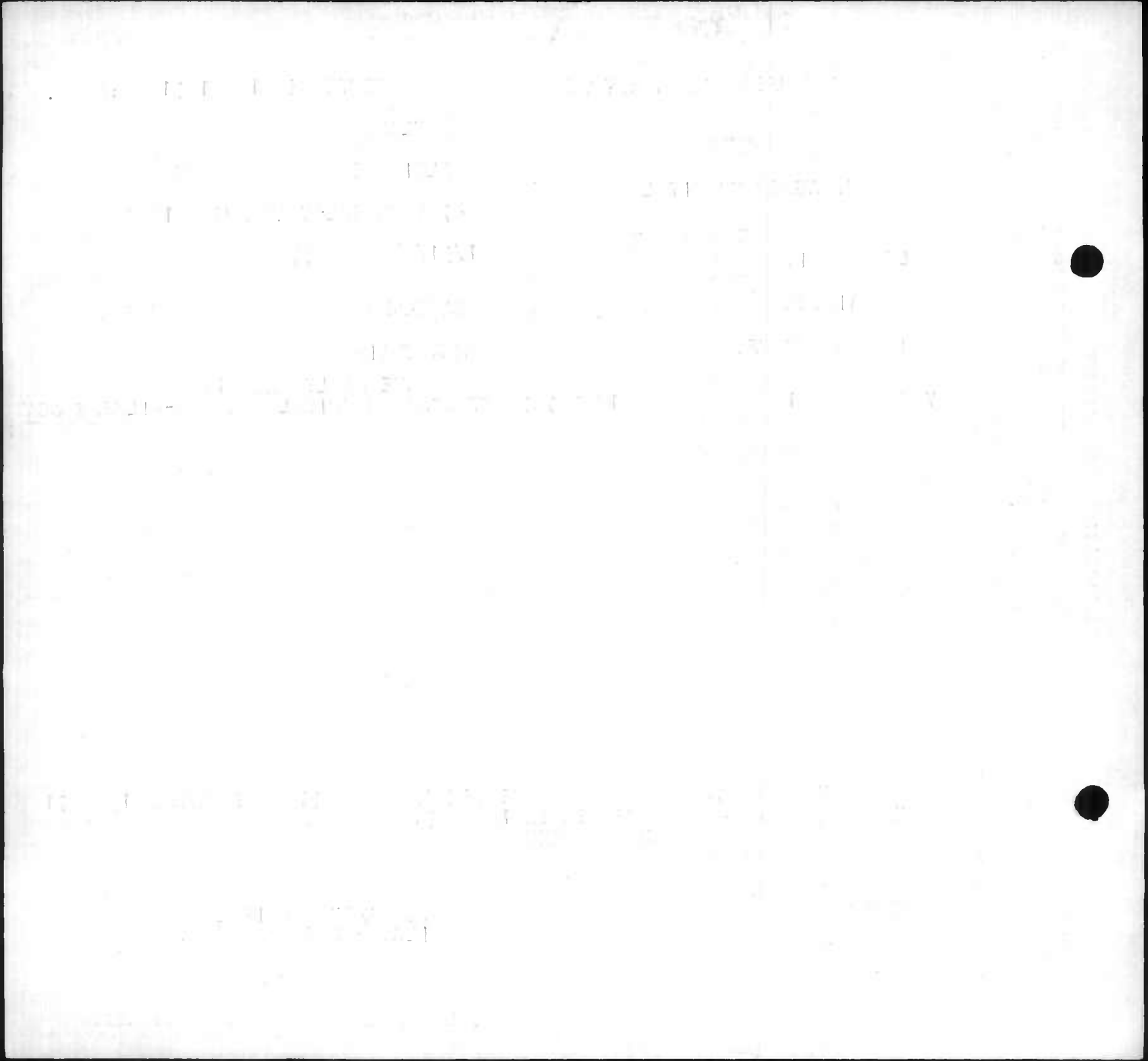
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8767</u>	
BIRTH NO. <u>M-6271 8767</u>		2. DATE AND HOUR OF DEATH <u>9/17/71 9¹⁵ A.</u>	
1. NAME OF DECEASED (Type or Print) <u>EVA MEYERS</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>351</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Gould Convalescent Home</u> <u>6116 Belair Road</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>336 S. Spring Court</u>	
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/25/1898</u> 9. AGE (in years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Char woman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fidelity & Deposit</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-14-5106A</u>	17. INFORMANT ADDRESS <u>Albert W. Meyers, 33 N. Kresson St., 21224</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hypertension, Atherosclerosis, Chronic Bronchitis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/23/1971</u> to <u>9/17/1971</u> that (I) (<u>we</u>) last saw the deceased alive on <u>9/17/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did not) view the body after death.			
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>9/17/71</u>	23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/18/71</u>	24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>
24D. LOCATION <u>Glen Burnie, Maryland</u>		24E. FUNERAL DIRECTOR ADDRESS <u>Witzke, 1650 Edmondson Avenue, 21228</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>W. J. Witzke, Jr.</u>	



FUNERAL DIRECTOR: IMPORTANT

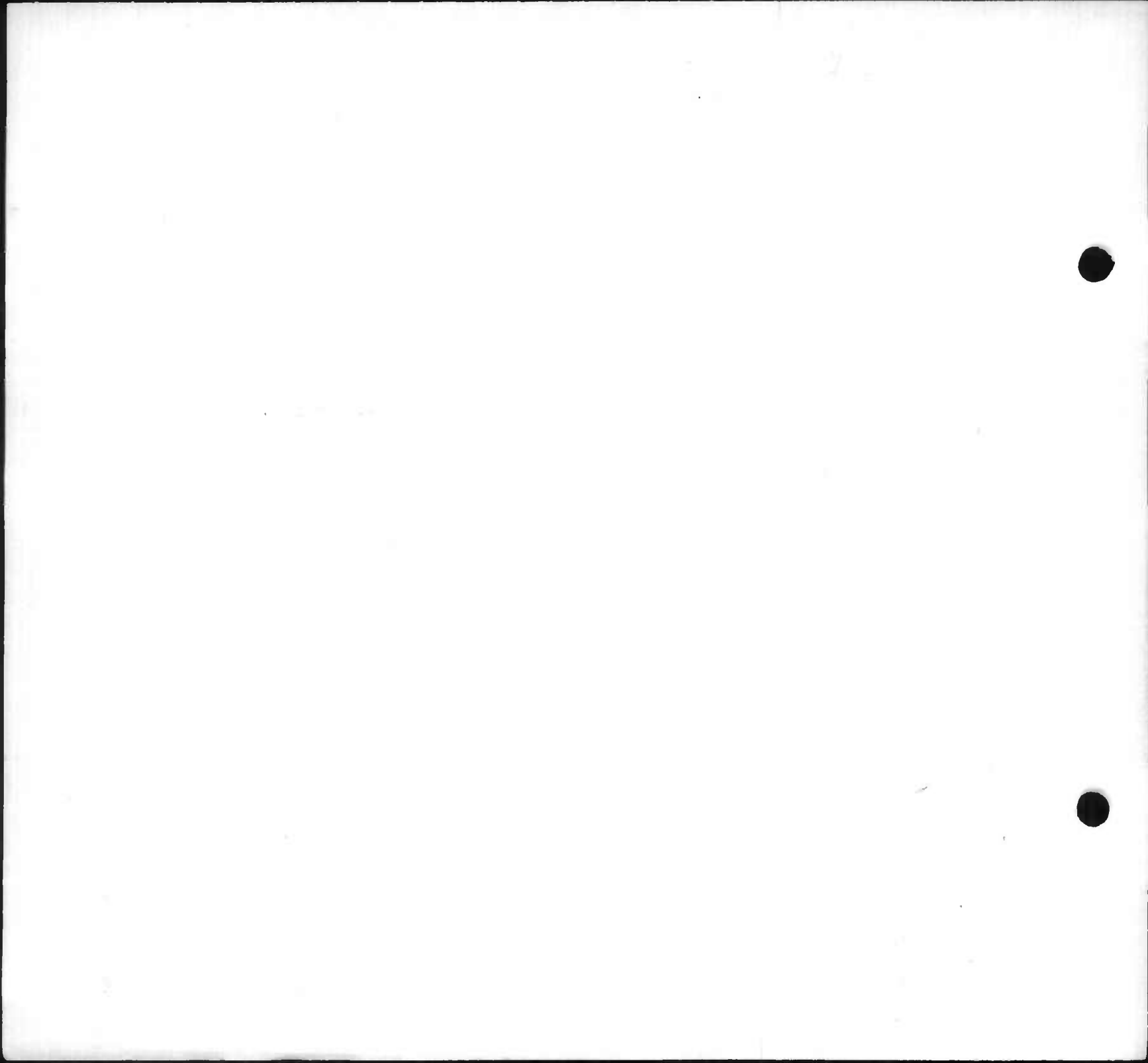
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8768</u>	
S-616 71 8768				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SCHRUFER, HENRY ANTONE		2. DATE AND HOUR OF DEATH SEPTEMBER 19, 1971 2:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4704 AMBERLEY AVENUE 21229	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/31/94	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY General Electric		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN W SCHRUFER		14. MOTHER'S MAIDEN NAME EMMA SWAIN		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 215098787		17. INFORMANT AVE BA LTO MD 21229 ADDRESS ST AGNES HOSPITAL RECORDS-WILKENS & CATON	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emboli. Suspected		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure (Chronic)			
		(C) Chronic Rheumatic heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION ○		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 8, 1971 to SEPTEMBER 19, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 19, 1971 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eitatsu Henzan MD		23B. DATE SIGNED 9/19/71		23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/71		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Witzke	
25C. FUNERAL DIRECTOR Witzke		25D. ADDRESS 1630 Edmondson Avenue 21228			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

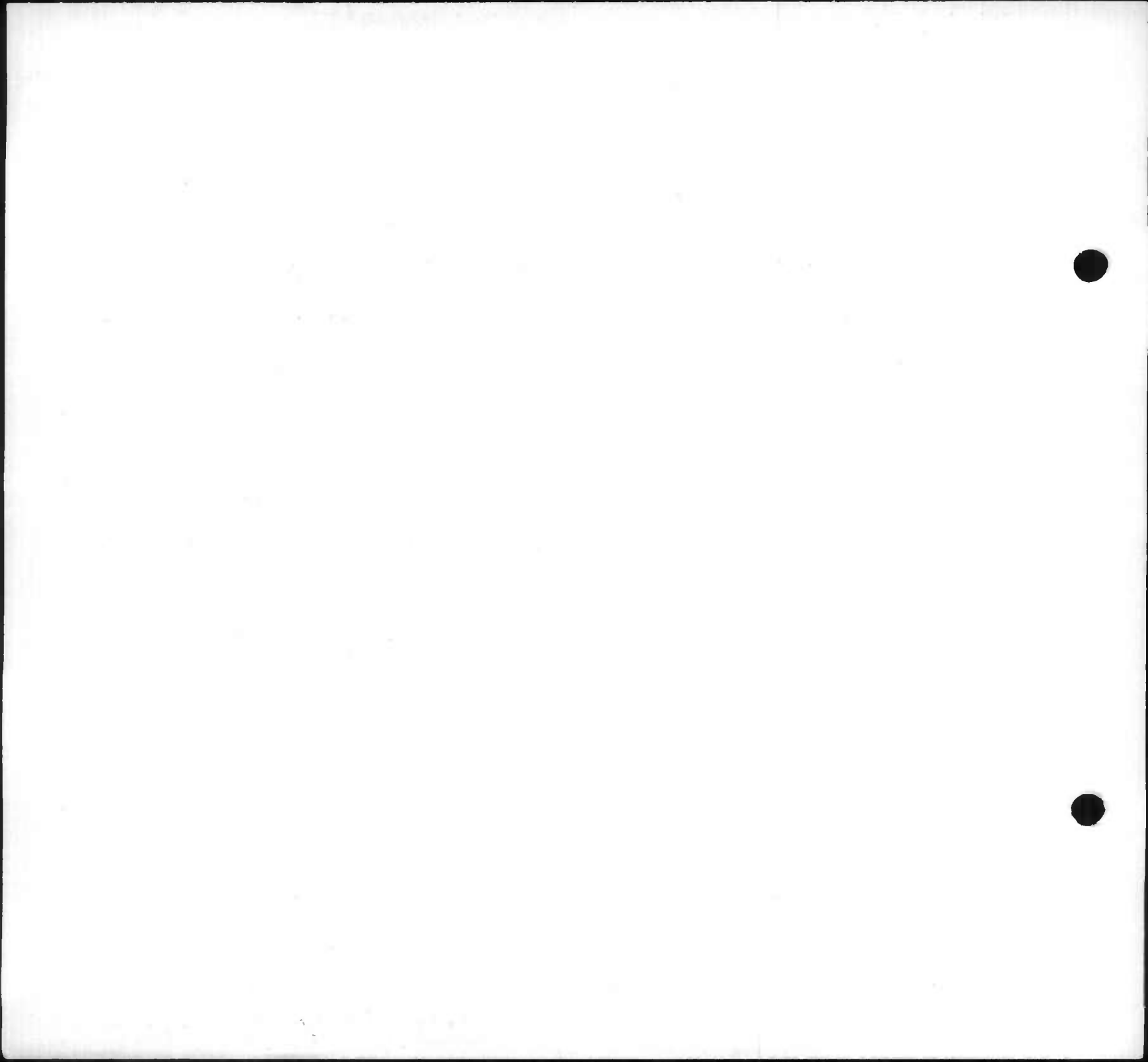
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8769	
<div style="display: flex; justify-content: space-between;"> S-53071 8769 </div>							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <i>Boon Secours Hospital Louis H. Smith</i>				2. DATE AND HOUR OF DEATH <i>9/18/71 10:10 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Boon Secours Hospital</i> <i>34</i>				A. STATE <i>Mo.</i> B. COUNTY <i>Baltimore</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>BALTO.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>1229 North Rolling Road</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/9/15</i>	9. AGE (in years last birthday) <i>56</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SELF EMPLOYED</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>STORE</i>		11. BIRTHPLACE (State or foreign country) <i>Mo.</i>	
13. FATHER'S NAME <i>Louis Smith</i>				14. MOTHER'S MAIDEN NAME <i>Clara Heiner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>CHART Mrs. Louis H. Smith</i>	
				ADDRESS <i>21228</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
				ADDRESS <i>1229 Rolling Rd</i>			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>HEPATIC INSUFFICIENCY</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>METASTATIC CO. - LIVER</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <i>pos. Carcinoma of the Colon</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-11</i> 19 <i>71</i> to <i>9-18</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10:25 PM 9-18 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ramiro Lindado</i>				23B. DATE SIGNED <i>9-18-71</i>		23C. PHYSICIAN'S NAME (Type) <i>RAMIRO LINDADO</i>	
23D. ADDRESS <i>Boon Secours Hospital</i>				23E. FURNERAL DIRECTOR <i>Witzke</i>		23F. ADDRESS <i>1630 Edmondson Avenue 21228</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>9/22/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21229</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Gaber, M.D.</i>		25C. FURNERAL DIRECTOR <i>Witzke</i>		25D. ADDRESS <i>1630 Edmondson Avenue 21228</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

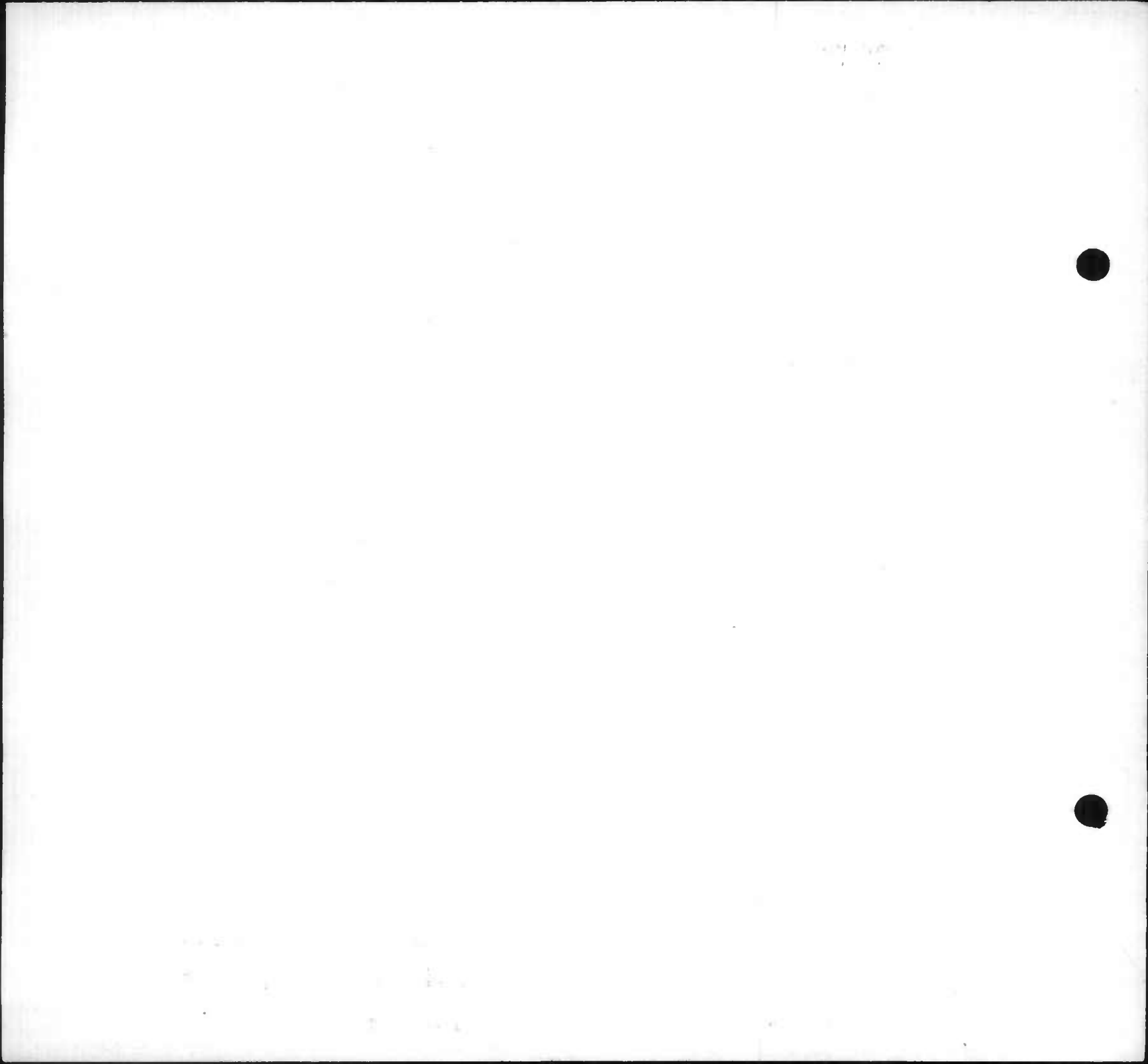
B-346 71 8770		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8770	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HATTIE BUTLER</u>		2. DATE AND HOUR OF DEATH <u>9-19-71</u> <u>1</u> <u>19</u> <u>A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 BON SECOURS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> 8. COUNTY <u>1903</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1628 HOLLINS ST</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-20-13</u>	9. AGE (in years last birthday) <u>57</u>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
13. FATHER'S NAME <u>James A Higgins (late)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jean Moore, 1620 Hollins Street 21223</u>	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recent Myocardial Infarct</u> <u>Post. Wall of Left Ventr</u> (B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pulmonary edema</u>		<u>1 day</u>			
19A. DATE OF OPERATION <u>9-19-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-19</u> <u>19 71</u> to <u>9-19</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>9-19</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ramiro Lindado</u>		DEGREE <u>RAMIRO LINDADO</u>		23B. DATE SIGNED <u>9-19-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAMIRO LINDADO</u>		23D. ADDRESS <u>BON SECOURS Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/21/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven</u>	
24D. LOCATION <u>Glen Burnie, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

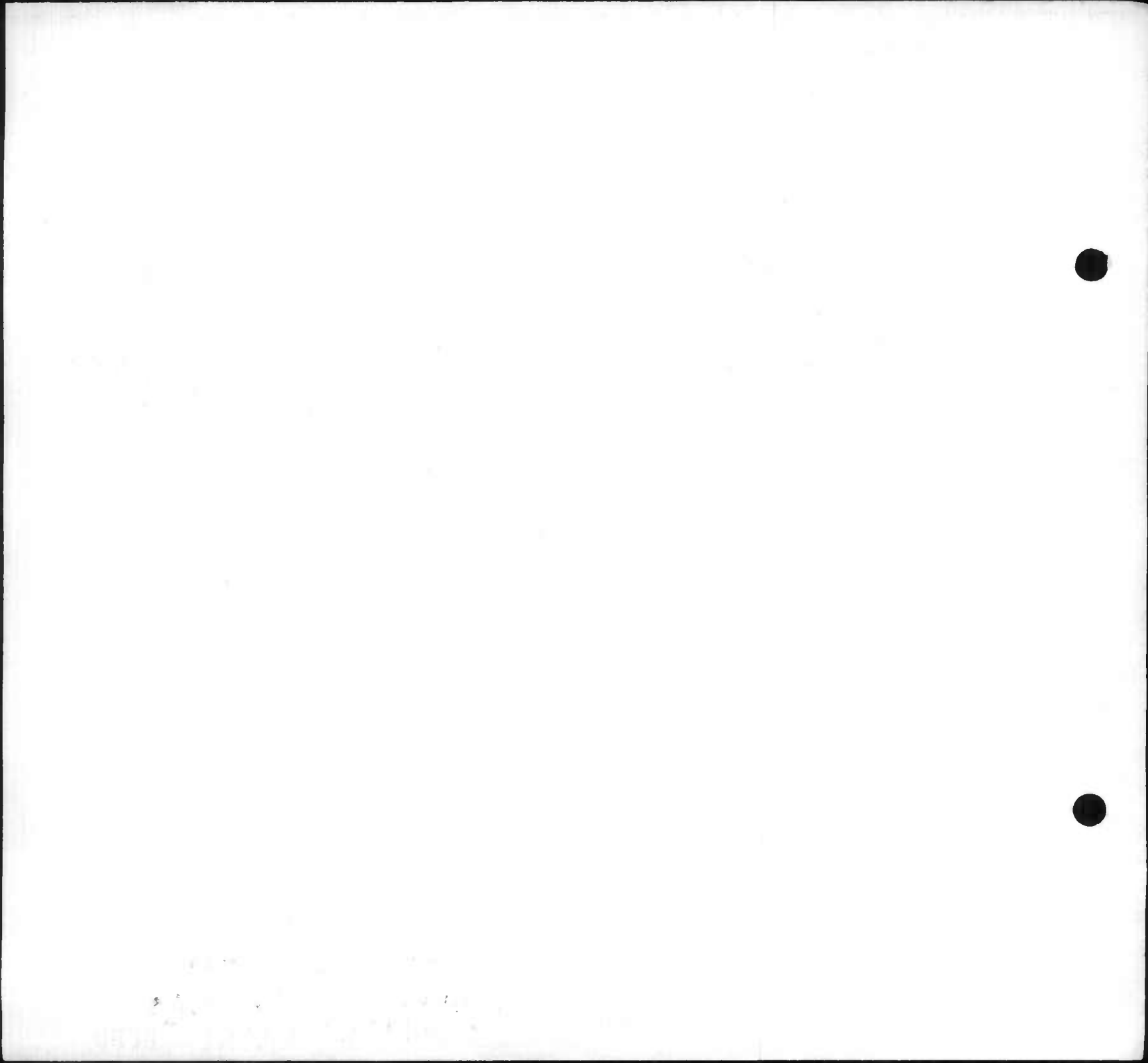
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8771	
CERTIFICATE OF DEATH					
T-520 BIRTH NO. 11-1376471 8771					
1. NAME OF DECEASED (Type or Print) BABY BOY THOMAS		2. DATE AND HOUR OF DEATH 9/5/71 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1502			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1520 MC KEAN AVE.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/71	9. AGE (in years last birthday) 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME MICHAEL L. THOMAS		14. MOTHER'S MAIDEN NAME DOROTHY GRAVES. 1520 MC KEAN ST.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS JOANN CLAYTON SANTOS, M.D.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CNS HEMMORHAGE.				2 HRS.	
(B) DUE TO, OR AS A CONSEQUENCE OF: POSSIBLE SEPSIS				24 HRS.	
(C) DUE TO, OR AS A CONSEQUENCE OF: IMMATURITY					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYALINE MEMBRANE DISEASE					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 5 (9AM) 1971 to SEPT. 5 (11PM) 1971 that (I) (we) last saw the deceased alive on SEPT 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joann Clayton Santos M.D.				23B. DATE SIGNED 9/6/71	
23C. PHYSICIAN'S NAME (Type) JOANN CLAYTON SANTOS M.D.				23D. ADDRESS ANATOMY BOARD OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) HOSPITAL DISPOSAL		24B. DATE 9-15-71		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State) HOSPITAL DISPOSAL		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971			
25B. NAME OF REGISTRAR Robert E. Sabin, M.D.		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL			



FUNERAL DIRECTOR: IMPORTANT

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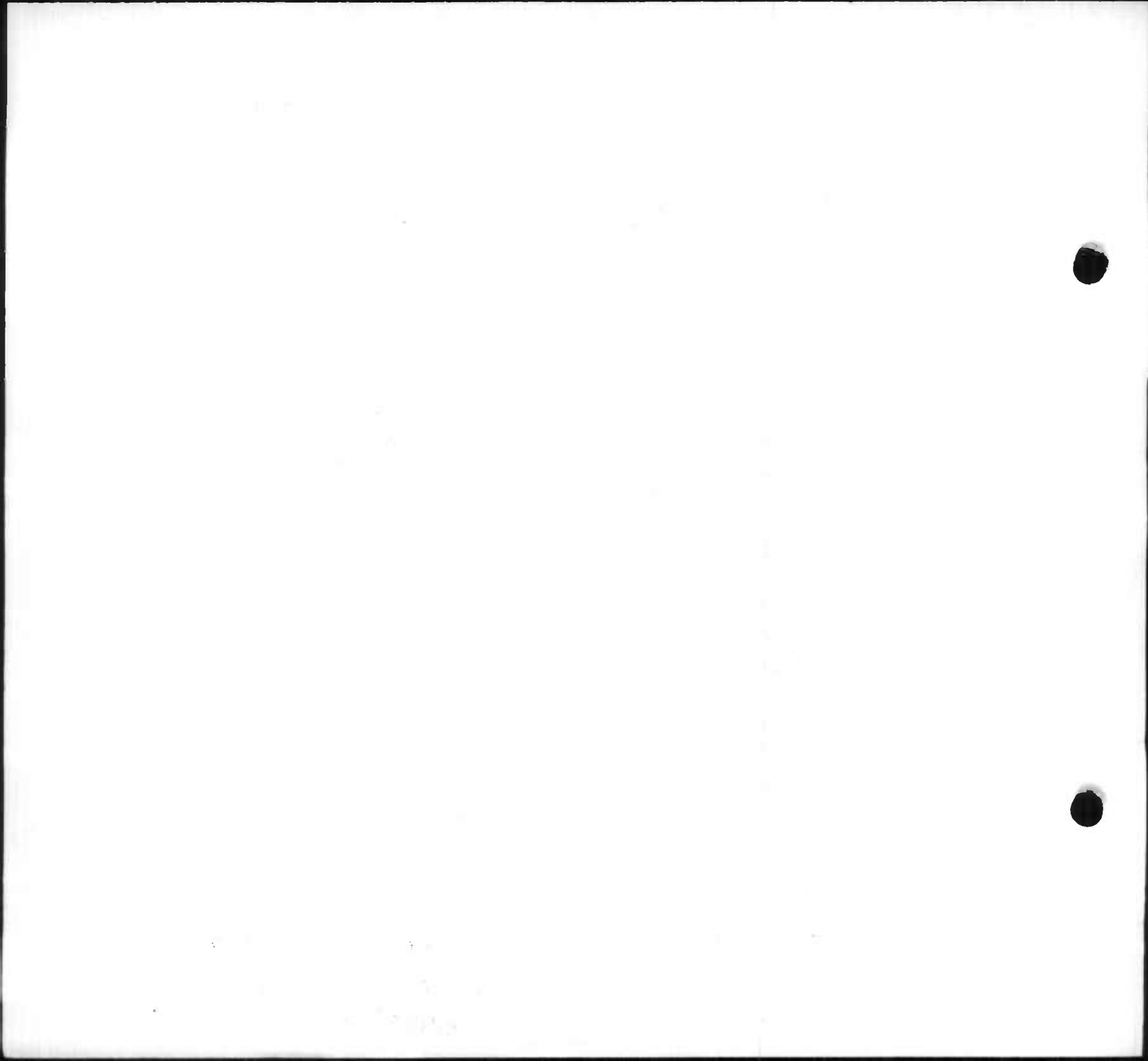
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>8772</u>	
BIRTH NO. <u>E-524</u> <u>71-152681</u> <u>8772</u>					
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL ENGLISH</u>		2. DATE AND HOUR OF DEATH <u>8/28/71</u> <u>8:10 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2843</u> C. CITY OR TOWN <u>CITY</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4718 Wakefield Rd Balto 21207</u>			
5. SEX <u>F</u>	6. RACE <u>NIGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/71</u>	9. AGE (In years last birthday) <u>2 d.</u>	If Under 1 Yr. Months: <u>1</u> Day: <u>1</u> If Under 24 Hrs. Hours: <u>1</u> Min: <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN.</u>			
14. MOTHER'S MAIDEN NAME <u>Eleanor English</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Eleanor</u> ADDRESS <u>SAME</u>			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain stem Hemorrhage 1 d.</u> (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hyaline membrane Disease 1 d.</u> (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 d.</u> <u>1 d.</u>	
19A. DATE OF OPERATION <u>8/27/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>-</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8/27/71</u> 19 <u>71</u> to <u>8/28/71</u> 19 <u>71</u> that (H) (we) lost saw the deceased alive on <u>8/27/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Schitt Chang</u>		23B. DATE SIGNED <u>8/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>SCHITT CHANG</u>	
23D. ADDRESS <u>University Hosp.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-14-71</u>			
24B. DATE <u>9-14-71</u>		24C. NAME OF CEMETERY or CREMATOR <u>ANATOMY BOARD OF MARYLAND</u>			
24D. NAME OF REGISTRAR <u>SEP 20 1971 Robert E. Jaber, M.D.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>			
25B. NAME OF REGISTRAR <u>SEP 20 1971</u>		25C. NAME OF REGISTRAR <u>SEP 20 1971</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

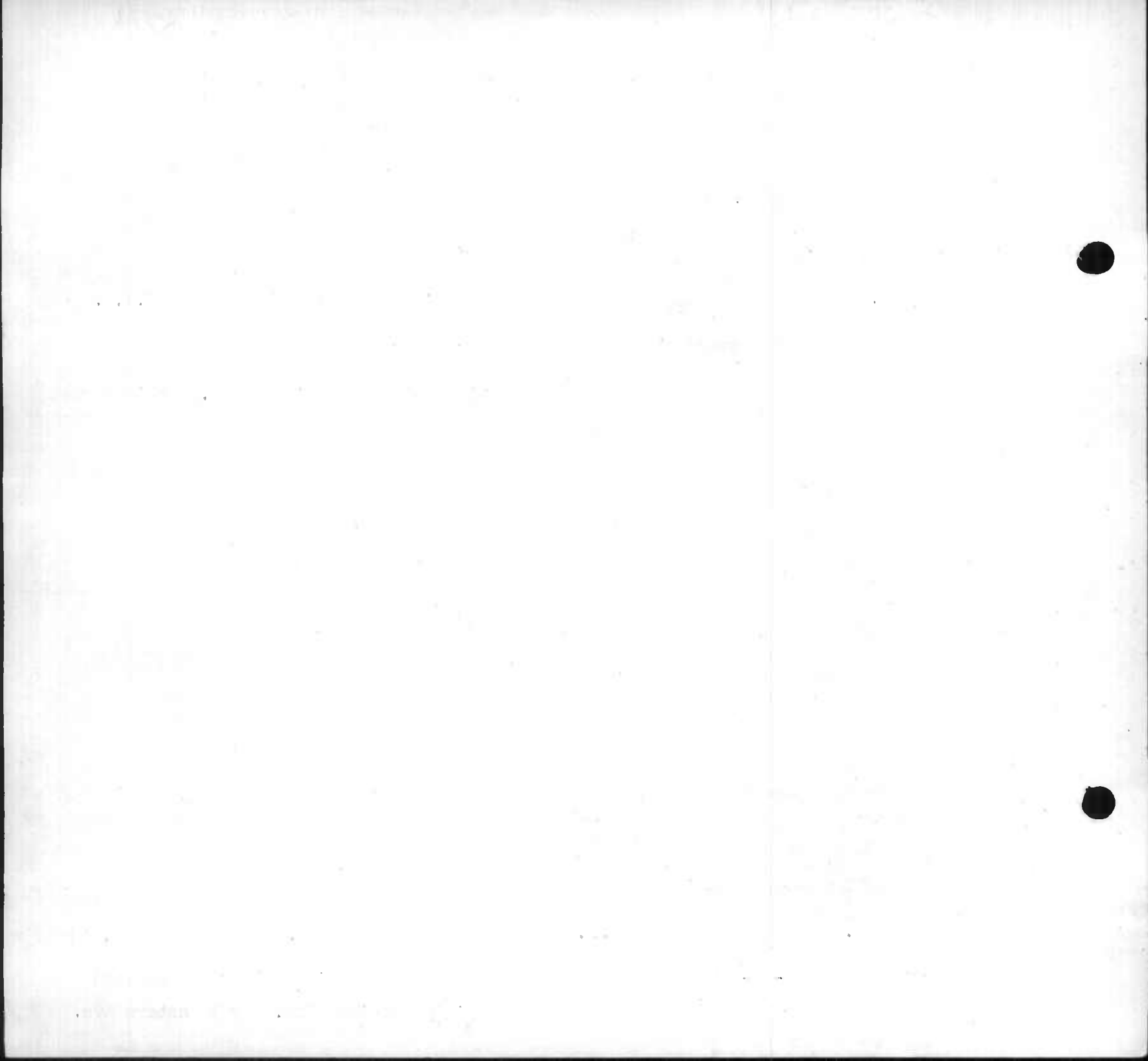
BIRTH NO. <u>71 8773</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8773</u>	
1. NAME OF DECEASED (Type or Print) <u>ALLISON, MARY A.</u>				2. DATE AND HOUR OF DEATH <u>Sept. 7, 1971</u> <u>2:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>701</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>516 N. POTOMAC STREET</u> <u>21205</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/05</u>	9. AGE (In years last birthday) <u>66 yrs</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Michael</u>				14. MOTHER'S MAIDEN NAME <u>Augusta</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH RECORDS-</u>		ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
18. <u>4367 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Bilateral CVA's</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>18 months</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from <u>4/9/71</u> 19 <u>70</u> to <u>9/7</u> 19 <u>71</u> that (we) (we) last saw the deceased alive on <u>9/7</u> 19 <u>71</u> and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) <u>did</u> view the body after death.							
23A. SIGNATURE <u>W. Ramseur</u>				23B. DATE SIGNED <u>9/7/71</u> <u>2:45 AM</u>		23C. PHYSICIAN'S NAME (Type) <u>W. Ramseur, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-13-71</u>		24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, R.D.</u>		25C. FUNERAL DIRECTOR <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BALTIMORE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8774</u>	
BIRTH NO. <u>13 325 71 8774</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CATHERINE CROSS (BUDZYNSKI)			2. DATE AND HOUR OF DEATH September 17, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1315 Gregor Way			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2636 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1315 Gregor Way		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1897		9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Leon Kosakowski		
14. MOTHER'S MAIDEN NAME Mary			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Theodore Budzynski 328 S. Joplin Street		
18. 412.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior-splenic Cardio-Vascular disease, generalized severe. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None 19A. DATE OF OPERATION none 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from July 1942 to Sept 17, 1971 , that (I) (we) last saw the deceased alive on Sept 17, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. 23A. SIGNATURE E. Roderick Shipley MD 23B. DATE SIGNED September 17, 1971 23C. PHYSICIAN'S NAME (Type) E. Roderick Shipley, M.D. 23D. ADDRESS 529 Camp Meade Rd., Linthicum, Md. 21090 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9-20-1971 24C. NAME OF CEMETERY or CREMATORY Holy Rosary 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971 25B. NAME OF REGISTRAR Robert E. Tabor, M.D. 25C. FUNERAL DIRECTOR ADDRESS Hilly & Zeiler Inc. 1901 Eastern Ave.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8775</u>	
BIRTH NO. <u>71 8775</u>					
1. NAME OF DECEASED (Type or Print) <u>Claude Kinard</u>		2. DATE AND HOUR OF DEATH <u>6:19 AM, 9 Sept 1971</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>808</u>			
5. SEX <u>M</u> 6. RACE <u>N.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-99</u> 9. AGE (in years last birthday) <u>71</u>		10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>a variety</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> ADDRESS	
18. <u>269.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Congestive Heart Failure</u> (A) IMMEDIATE CAUSE <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Malabsorbtion Syndrome</u> (C) <u>COPD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~15 years</u>					
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0 6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0 6</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Sept 1st</u> 19 <u>71</u> to <u>Sept 9</u> 19 <u>71</u> and that (2) (we) last saw the deceased alive on <u>1st</u> <u>Sept 9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George J. Taylor</u> MD DEGREE		23B. DATE SIGNED <u>9-9-71</u>		23C. PHYSICIAN'S NAME (Type) <u>George J. Taylor</u> MD DEGREE	
23D. ADDRESS <u>Baltimore</u>		23E. ADDRESS <u>Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem. Balto</u>	
24D. LOCATION (City, town, or county) <u>Md</u>		24E. LOCATION (State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>R. J. ...</u> ADDRESS <u>219 E. Preston St</u>	

1/11/11 Mr. J. H. P. & Co. Boston
215 Boston St.

FUNERAL DIRECTOR: IMPORTANT

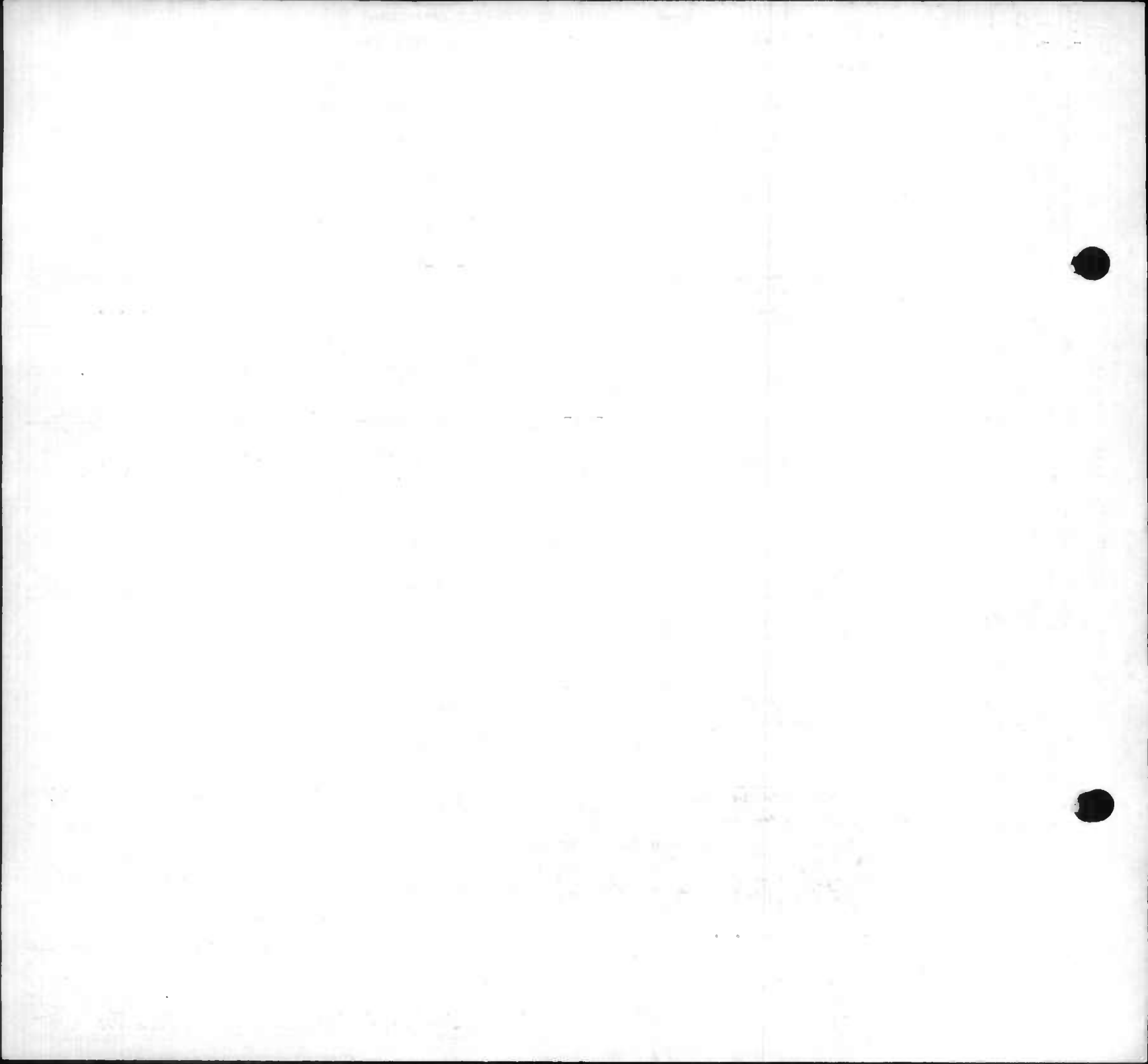
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 8776

BIRTH NO. 71 8776

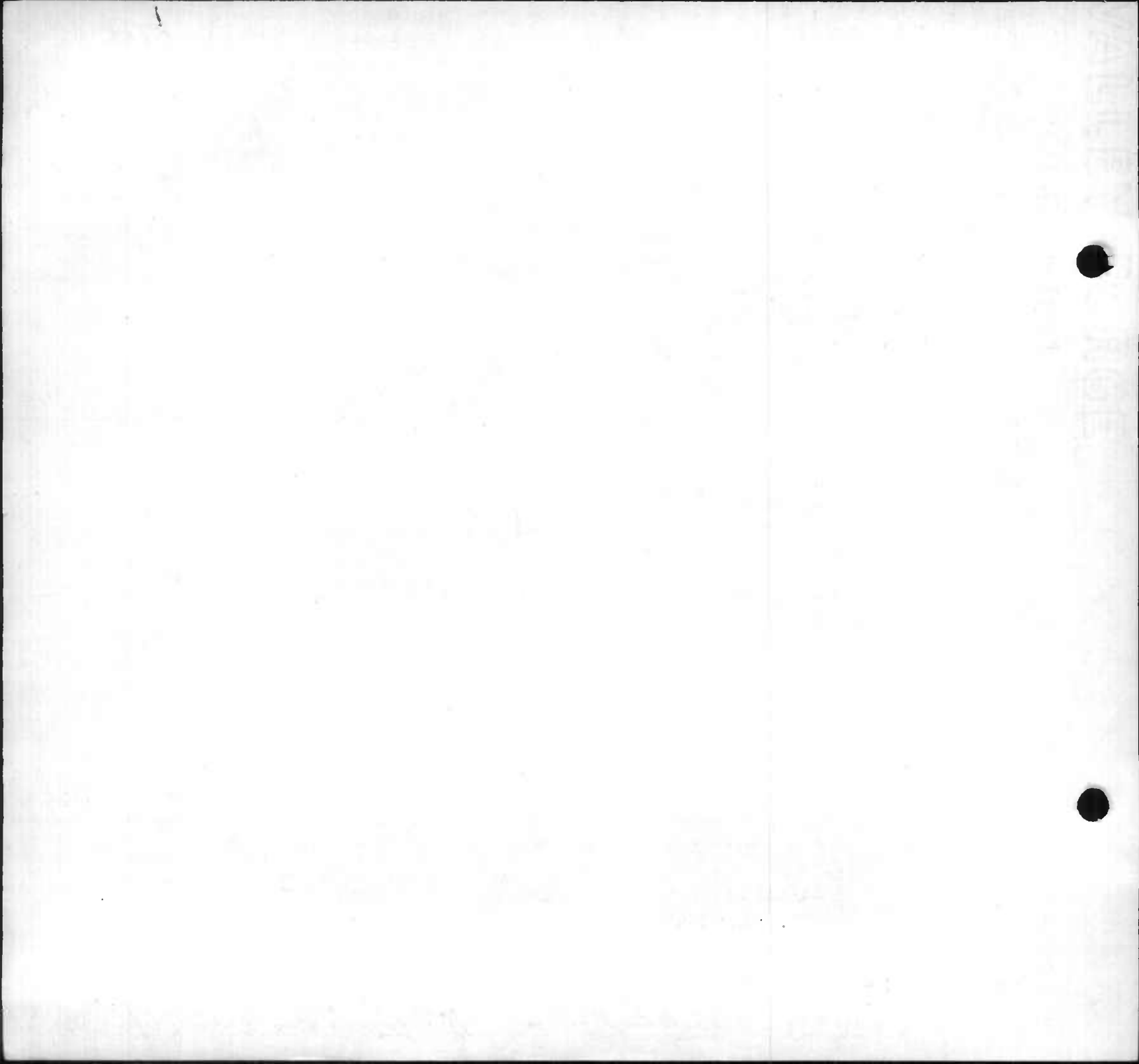
1. NAME OF DECEASED (Type or Print) <u>John R. Jones</u>		2. DATE AND HOUR OF DEATH <u>9/14/71</u> <u>8 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>908</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>725 East 20th Street</u> <u>21218</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-09</u>
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Long Shoreman</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bobbit</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>218-05-2115A</u>	
17. INFORMANT <u>BCH: Records</u>		ADDRESS <u>Baltimore, Maryland 21224</u>	
18. <u>150X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Esophagus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Brain Damage 2°</u> <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>05-11-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ESOPHAGUS OBSTRUCTION</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>6/15</u> 19 <u>71</u> to <u>9/14</u> 19 <u>71</u> that <u>he</u> (we) last saw the deceased alive on <u>9/14</u> 19 <u>71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I <u>do</u> (did) <u>not</u> view the body after death.			
23A. SIGNATURE <u>W. Ramseur</u> M.D.		23B. DATE SIGNED <u>9/14/71</u> <u>8 AM</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. Ramseur, M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-17-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Em Balto</u>		24D. LOCATION (City, town, or county) <u>Md</u> (State) <u>Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Rayner Sanders</u>		ADDRESS <u>217 E Preston St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

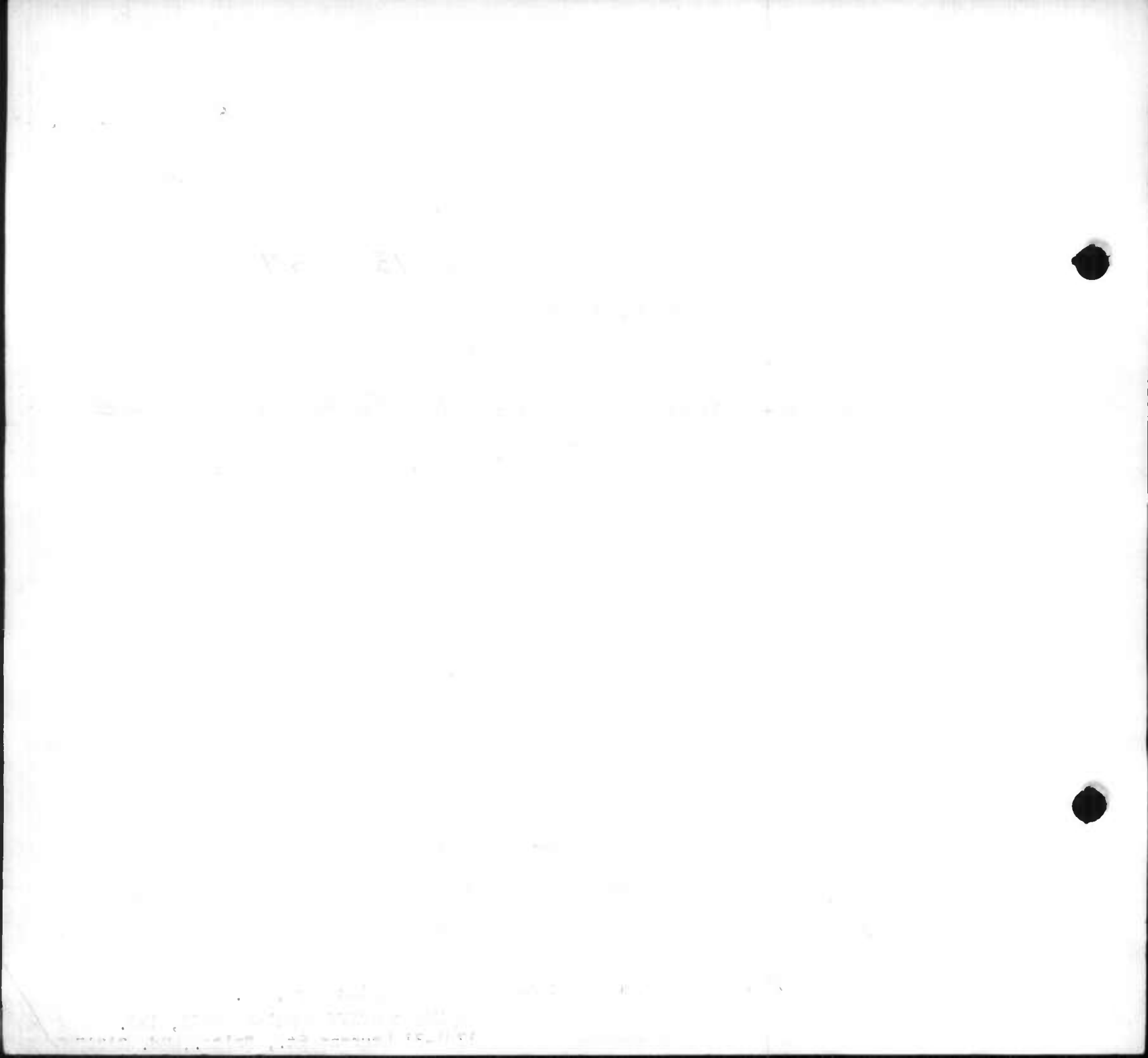
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8777	
BIRTH NO. 71 8777		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BROWN ROSETTA.			2. DATE AND HOUR OF DEATH 9.15.71 1.30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1203		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 346 E 28th St.		
5. SEX Female	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.23.1915	9. AGE (In years last birthday) 56.	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME WALTER FARMER			14. MOTHER'S MAIDEN NAME Uyola Farmer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Patsy Moore 4342 Grand Ave
18. 182.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Elect. Imbalance (B) DUE TO, OR AS A CONSEQUENCE OF: Ca. uteri - Per. metastasis (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8.6.71 19 to 8.11.71 20th that (I) (we) last saw the deceased alive on 9.15.71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ali Khan				23B. DATE SIGNED 9.15.71	
23C. PHYSICIAN'S NAME (Type) DR. ALI KHAN				23D. ADDRESS Denville Virginia	
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 9-18-71		24C. NAME OF CEMETERY or CREMATORY Denver	
24D. LOCATION (City, town, or county) (State) Denver Virginia		25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E Preston St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8778</u>	
BIRTH NO. <u>25071 8778</u>					
1. NAME OF DECEASED (Type or Print) <u>JACKSON EUGENE</u>			2. DATE AND HOUR OF DEATH <u>10:30 9/16/71</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u> <u>38</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1503</u>		
5. SEX <u>M</u> 6. RACE <u>BLACK</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10/2/13</u> 9. AGE (in years) <u>57</u> lost birth <u>57</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)
			<u>GAS & ELEC.</u>		<u>Newberry S.C.</u>
13. FATHER'S NAME <u>JERRY JACKSON</u>			14. MOTHER'S MAIDEN NAME <u>MARY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES 13 Feb 41 - 21 Dec 45</u>			16. SOCIAL SECURITY NO. <u>217-097138</u>		17. INFORMANT <u>MARY JACKSON</u>
					ADDRESS <u>SAME</u>
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><u>514 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p><u>Fibrosing interstitial Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8/25</u> 19 <u>71</u> to <u>9/16</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. C. Alevizatos</u>			23B. DATE SIGNED <u>9/17/71</u>		23C. PHYSICIAN'S NAME (Type) <u>D. C. ALEVIZATOS</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>9/20/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Garden of Eternal Hope</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>			25B. NAME OF REGISTRAR <u>Paul E. B. [unclear]</u>		25C. FUNERAL DIRECTOR <u>MORTON & DYER</u>
					ADDRESS <u>1701-31 Laurens St., Balto., Md. 21217</u>



B-500

B-520

71

8779

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8779

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(BEAN)
Samuel Beames, Sr.

2. DATE OF DEATH
Known ☒ Estimated ☐
Month Day Year Hour
9 16 71 10:35 PM

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

3. DATE PRONOUNCED DEAD
Month Day Year Hour
9 16 71 10:35 PM

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 1403

6. SEX

male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5/15/07

10. AGE (In years last birthday)

64

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2023 Pennsylvania Avenue

11. BIRTHPLACE (State or foreign country)

Montgomery, Ala.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lon Bean

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lorean Bean

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

17. SOCIAL SECURITY NO.
719-09-4917

18. INFORMANT

Mr. Samuel Bean, Jr. 2023 Penna Ave. 21217

19.

412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Peter Lipkovic
Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/71

24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL

24B. DATE

9/21/71

24C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State)
Balto., Md.

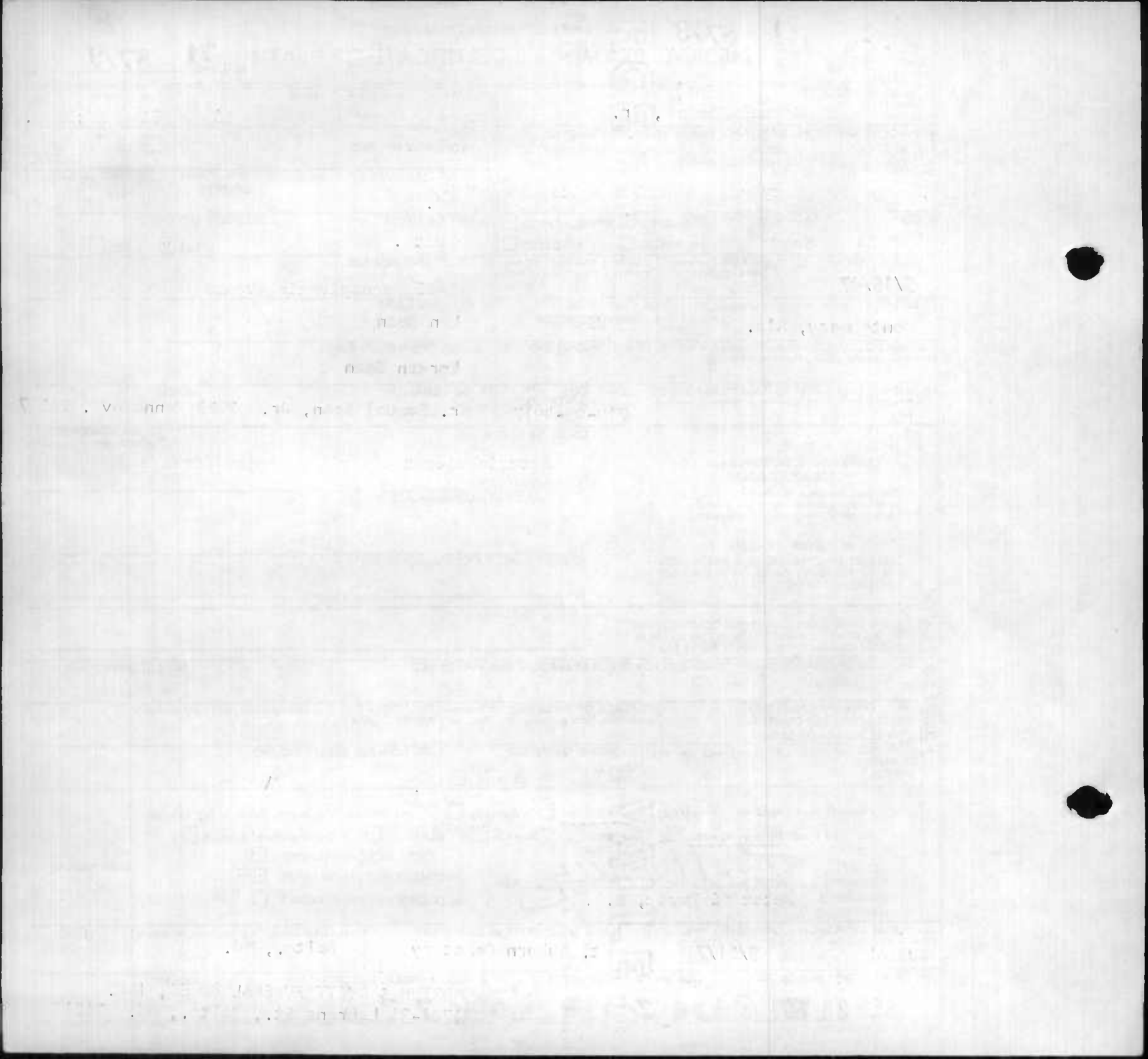
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOMES, INC.

1707-31 Laurens St., Balto., Md. 21217



CERTIFICATE OF DEATH

REG. NO. 71 8780

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ADAMS, I NEEA

2. DATE AND HOUR OF DEATH

9/17/71 3:51 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE DECEASED DIED

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

Baltimore, Maryland 21224
BALTIMORE CITY HOSPITAL
4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY
Maryland, Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

214 Center St. 21222 005

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-16-16

9. AGE (In years last birthday)

55

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Gibson, N. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Richard Adams

14. MOTHER'S MAIDEN NAME

Margaret Davis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH-Records Baltimore, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

METASTATIC CARCINOMA OF

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

BREAST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Eduardo Barboza MD.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

9/17/71

23C. PHYSICIAN'S NAME (Type)

Eduardo Barboza

MD.

23D. ADDRESS

4940 Eastern Avenue
BCH- Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/22/71

24C. NAME OF CEMETERY OR CREMATORY

Westview Cemetery

24D. LOCATION (City, town, or county) (State)

Hamlet, N. C. Gibson, N. C.

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1971

25B. NAME OF REGISTRAR

Robert E. Taylor MD.

25C. FUNERAL DIRECTOR

MORTON & DYETT FUNERAL HOMES, INC.

ADDRESS

1701-31 Laurens St., Balto., Md. 21217

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

10/5/71 - Correction form from funeral director.

Spec.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450

71 8781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8781

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND ALLEN

2. DATE AND HOUR OF DEATH

9/18/71

1 15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

808

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1107 McDonough Street 21213

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

8-11-15

9. AGE (In years
last birthday)

56

11 Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

N/A

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Gus Allen

14. MOTHER'S MAIDEN NAME

Annie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH RECORDS:

4940 Eastern Avenue
Baltimore, Maryland 21224

18.

436.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(L) CVA

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1-2 weeks

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).CHF prob 2° ASCVD
prob Tricuspid Insuff.

C.O.P.D.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from 8/12 1971 to 9/18 1971
that (B) (we) last saw the deceased alive on 9/18 1971 and that in (C) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.

23A. SIGNATURE

W.L. Ramsey

MD. DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9/18/71

23C. PHYSICIAN'S
NAME (Type)

W.L. RAMSEUR

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-24-71

24C. NAME of CEMETERY or CREMATORY

Family Lot

Baltimore, Maryland, (City, town or county)

Richmond,

Virginia (State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1971

25B. NAME OF REGISTRAR

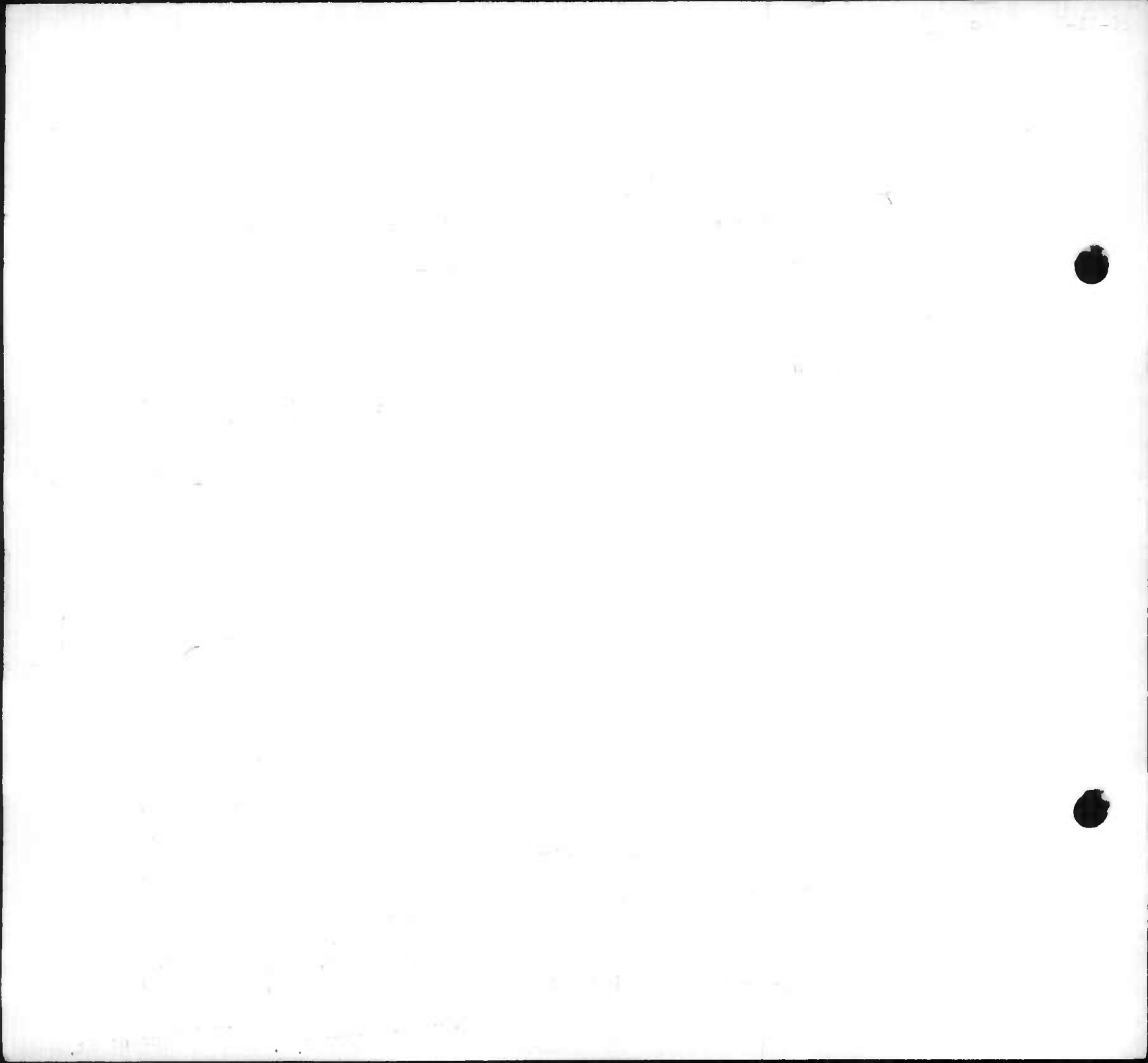
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT F. H.

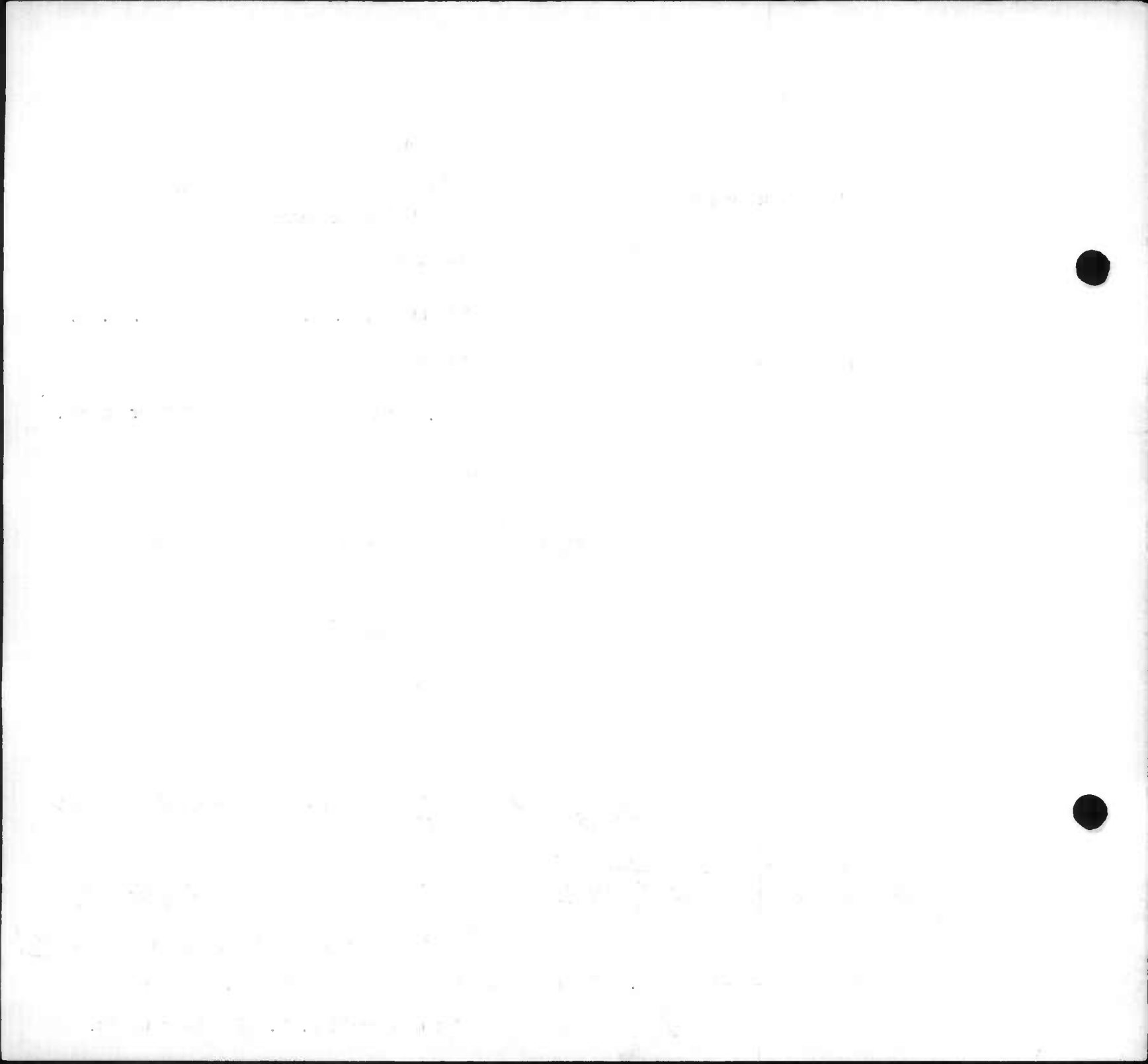
ADDRESS

1701 Laurens St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

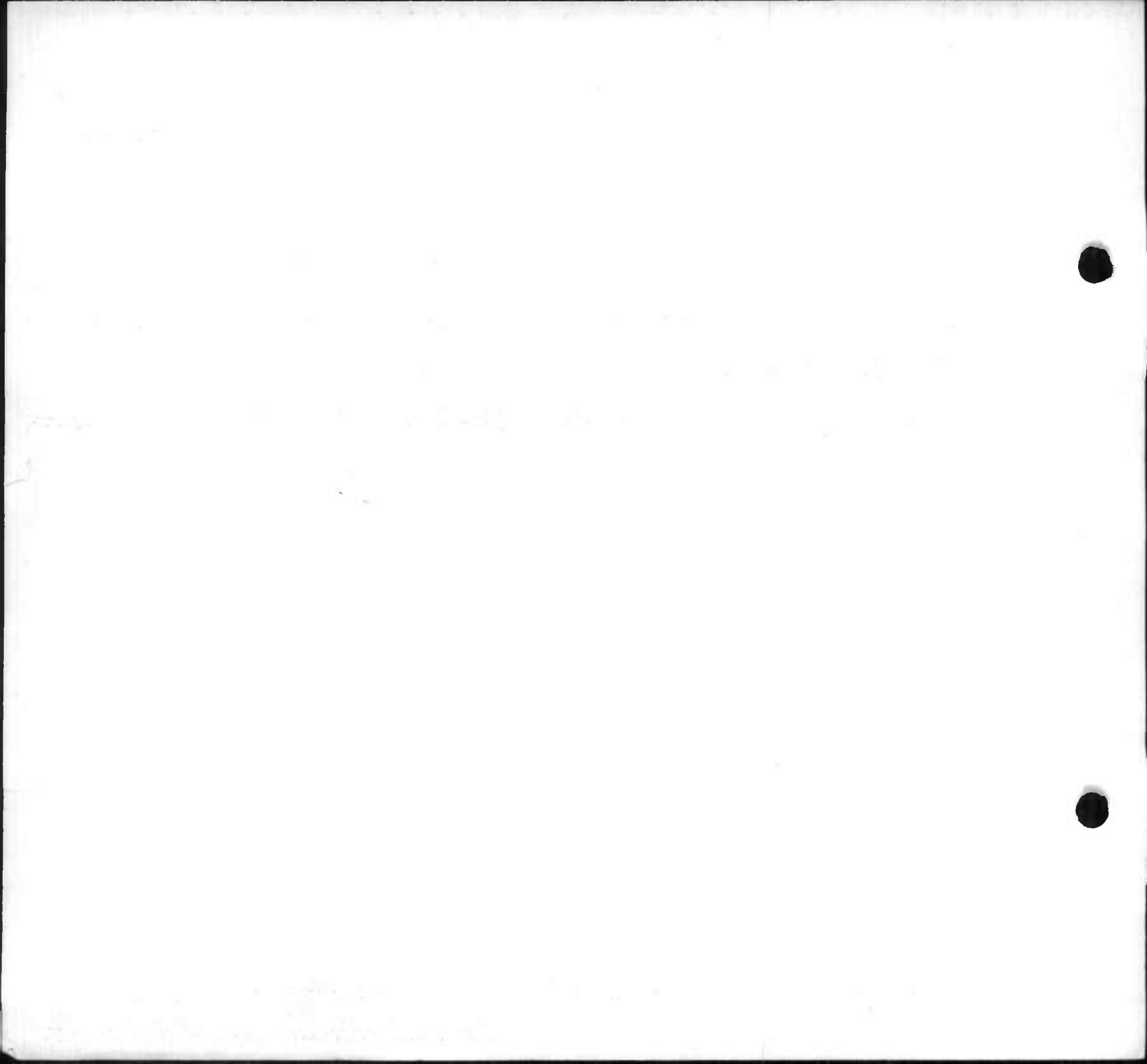
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8782	
BIRTH NO. 11200 71 8782					
1. NAME OF DECEASED (Type or Print) Arthur McGee			2. DATE AND HOUR OF DEATH 9-16-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2925 Walbrook Avenue			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1506		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2925 Walbrook Avenue		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenwood, S. C.	
13. FATHER'S NAME Flander McGee		14. MOTHER'S MAIDEN NAME Lillie McGee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hattie McGee	
				ADDRESS 2925 Walbrook Ave.	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertensive Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Rheumatoid Arthritis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-15-1966 to 9-13-1971 that (I) (we) last saw the deceased alive on 9-13-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James C. Priest, M.D.			23B. DATE SIGNED 9-18-71		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS 3101 Gaymans Falls Hwy Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-20-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
			24D. LOCATION Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H.	
				ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8783</u>
BIRTH NO. <u>525 71 8783</u>		1. NAME OF DECEASED (Type or Print) <u>ALAFAIR JENKINS</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>Sept 15, 1971</u> <u>1:15 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL,</u> <u>730 ASHBURTON ST., BALTIMORE,</u> <u>MD 21216</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1503</u>		
5. SEX <u>FEMALE</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		8. DATE OF BIRTH <u>01-1895</u>
13. FATHER'S NAME <u>James Green</u>		14. MOTHER'S MAIDEN NAME <u>Susan Green</u>		9. AGE (In years last birthday) <u>76</u>
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Honey Hill, S.C.</u>
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRO-VASCULAR ACCIDENT</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>SENILITY</u> (C) _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>9/14/1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>9/15/1971</u>
22. I certify that (I) (this hospital) attended the deceased from <u>9/14/1971</u> to <u>9/15/1971</u> that (I) (we) last saw the deceased alive on <u>9/15/1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Azad Cader</u>		23B. DATE SIGNED <u>9/15/71</u>		23C. PHYSICIAN'S NAME (Type) <u>AZAD CADER</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>9-18-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Goodwill Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Randolph J. Collick</u>		25C. FUNERAL DIRECTOR <u>2431 E. Oliver St.</u>



71 8784
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 8784

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joe Joseph Cosby Sr.</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>9</u> Day <u>16</u> Year <u>71</u> Hour <u>10:30</u> AM Estimated <input type="checkbox"/> Month <u>9</u> Day <u>16</u> Year <u>71</u> Hour <u>10:30</u> AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> 1523 E. 28th Street		3. DATE PRONOUNCED DEAD Month <u>9</u> Day <u>16</u> Year <u>71</u> Hour <u>10:30</u> AM		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>907</u>	
6. SEX <u>Male</u>	7. RACE <u>Negro</u>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>10-7-1892</u>		10. AGE (In years last birthday) <u>78</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <u>Glen Allen, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		E. STREET AND NUMBER <u>1523 E. 28th Street</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Public</u>		13. FATHER'S NAME <u>Moses Cosby</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>28-301005-A</u>		15. MOTHER'S MAIDEN NAME <u>Esther Thomas</u>	
18. INFORMANT <u>Annie Cosby</u>		ADDRESS <u>1523 E. 28th St.</u>		19. <u>185X</u> CAUSE OF DEATH	
MEDICAL CERTIFICATION DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <u>Carcinoma of prostate with metastases</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____ DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>No</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles S. Springate</u> EXAMINER'S NAME (Type)		M.D. <u>Charles S. Springate, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-20-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Crem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Paul E. Jones</u>	
25C. FUNERAL DIRECTOR <u>Randolph J. Collick</u>		ADDRESS <u>2431 E. Oliver St.</u>			

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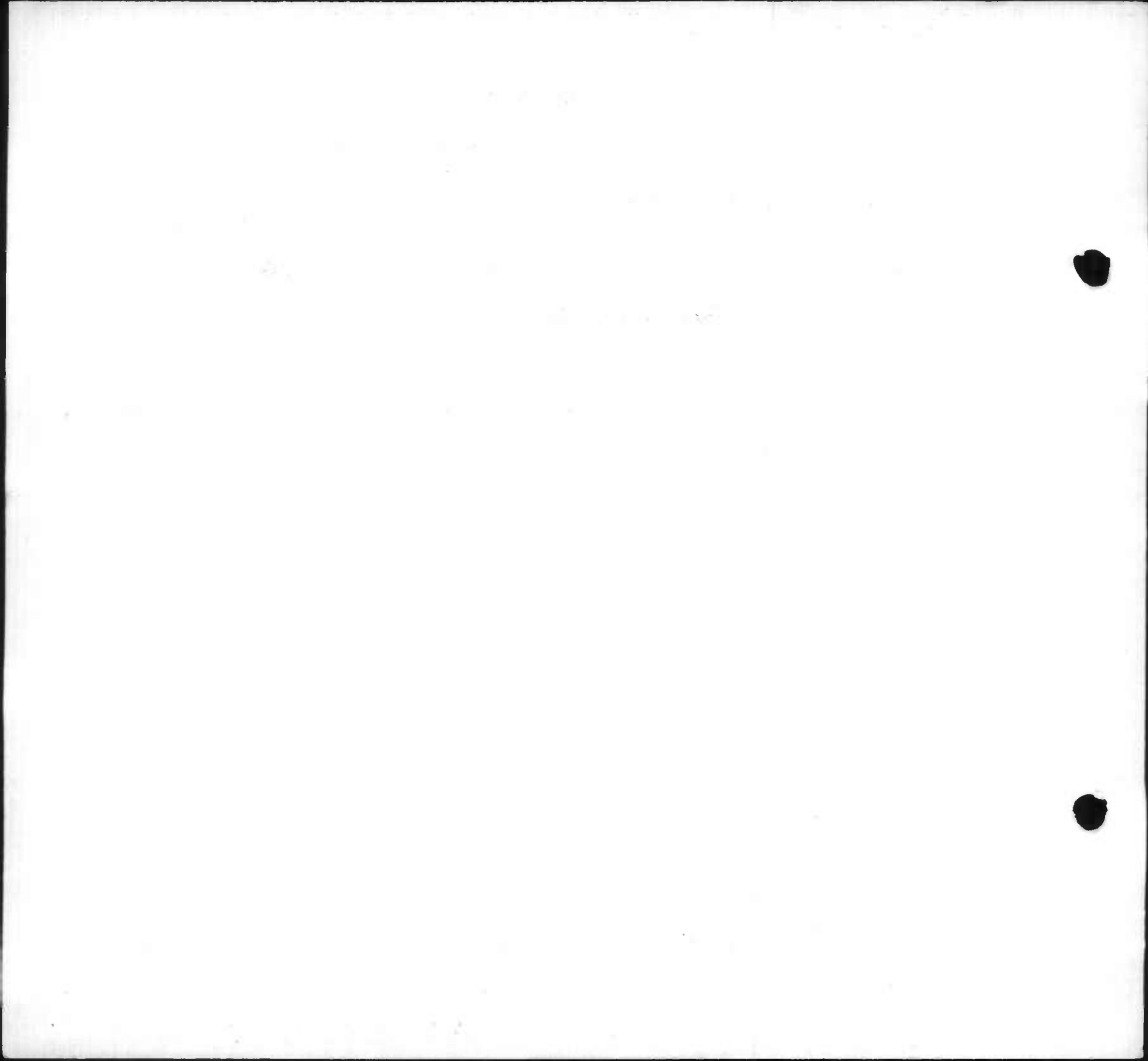
AND DETENT

WILLIAMSON CO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

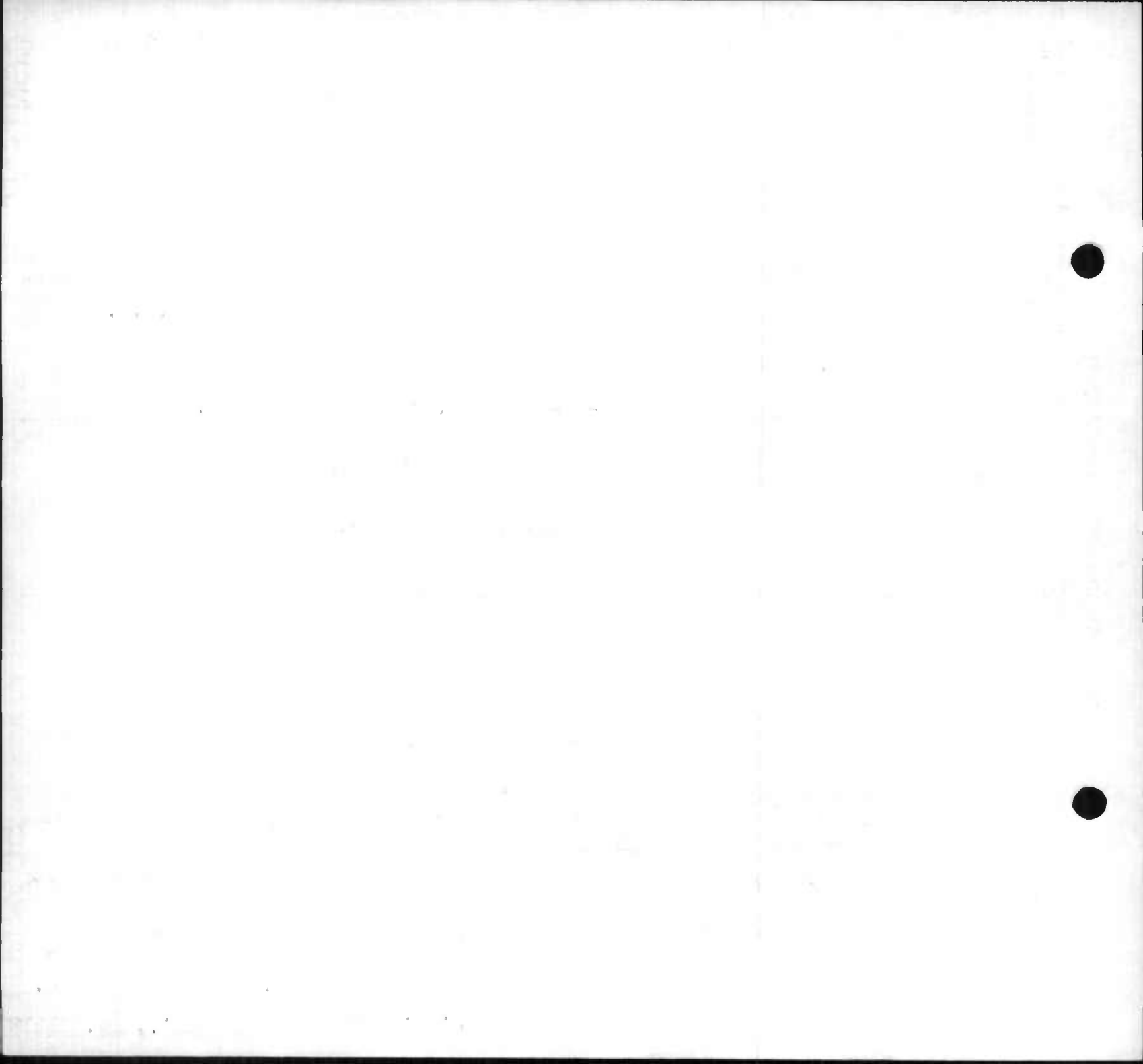
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8785</u>	
D-515 71 8785				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. Nellie C. Donavin</u>		2. DATE AND HOUR OF DEATH <u>9/19/71</u> <u>4⁰⁰ A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2720</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6901 Reisterstown Rd. #1215</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>01-21-95</u>	9. AGE (In years last birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Emerson Apts.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
13. FATHER'S NAME <u>Thomas Shamaher</u>			14. MOTHER'S MAIDEN NAME <u>Lisa Quinn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-0009</u>		17. INFORMANT <u>Vivian Syczrowski</u> ADDRESS <u>811 Venable Ave.</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>1) Arrhythmia due to myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>poss</u>					
(B) <u>2) Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 4</u> 19 <u>71</u> to <u>Sept. 19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept. 19, 4 AM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas S. Ahn M.D.</u>		23B. DATE SIGNED <u>Sept 19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>TAE S. AHN, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-22-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem.</u>	
24D. LOCATION <u>Pikesville</u>		24E. ADDRESS <u>Baltimore, Md.</u>		24F. NAME OF REGISTRAR <u>H. W. Jenkins Sons Co.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Valerie E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins Sons Co.</u>	
25D. ADDRESS <u>4905 York Rd.</u>		25E. ADDRESS <u>Baltimore, Md. 21212</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 8786	
W-52471 8786 BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lena G. Winslow</u>				2. DATE AND HOUR OF DEATH <u>9/18/71</u> <u>3 15</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hosp</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>30 OVER Ridge Court</u>			
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/29/88</u>		9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert J. Wright Garey</u>				14. MOTHER'S MAIDEN NAME <u>Vash T. Saulsbury</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-2462</u>		17. INFORMANT <u>Mr. Caleb Winslow, Sr.</u>		ADDRESS <u>Same</u>	
18. <u>45-1,91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SEPTIC SHOCK - PULMONA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>BY EMBOLI</u> (B) <u>THROMBOFLIBRIN - PERITONITIS (?)</u> DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>71</u> to <u>9/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joe P. Paz</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/18/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSE PAZ</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-21-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Homewood Friends</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>1905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

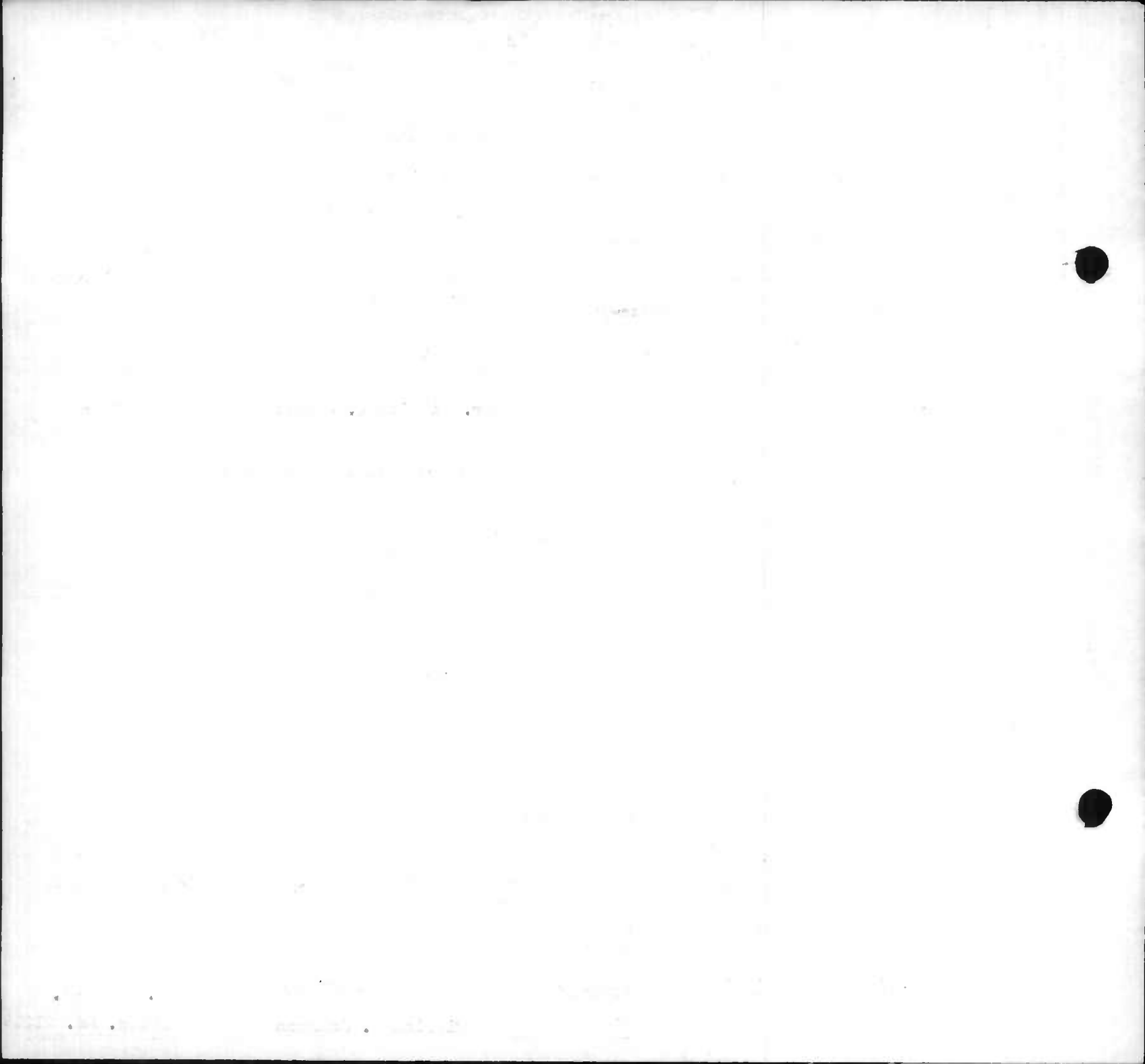
M-3081 8787				BIRTH NO.		REG. NO. 71 8787	
1. NAME OF DECEASED (Type or Print) <u>Meeth, Marie C</u>				2. DATE AND HOUR OF DEATH <u>9/17/71</u> <u>6:20</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Id</u> B. COUNTY <u>903</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>Balto, 33rd + Calvert Sts</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>33rd St 726</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/21/97</u>	9. AGE (In years, last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Joseph Carrick</u>				14. MOTHER'S MAIDEN NAME <u>Margaret M. GEEGHEGAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>12-30-4810</u>		17. INFORMANT <u>Jo M. Jones</u>			
				ADDRESS <u>5717 Roland Ave Balto 21210</u>			
18. <u>412.41 + 250.9</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>STAPHYLOCOCCAL SEPSIS</u>		<u>indefinite</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ABVD, GI bleeding, Diabetes mell.</u>		<u>Yrs</u>	
(C) <u>Contorture of extremities</u>						<u>Yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Contorture of extremities</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> 19 <u>71</u> to <u>9/17</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>9/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles F. Jones</u>				DEGREE		23B. DATE SIGNED <u>9/17/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. Fazekas MD</u>				23D. ADDRESS <u>14. M. H.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-21-71</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

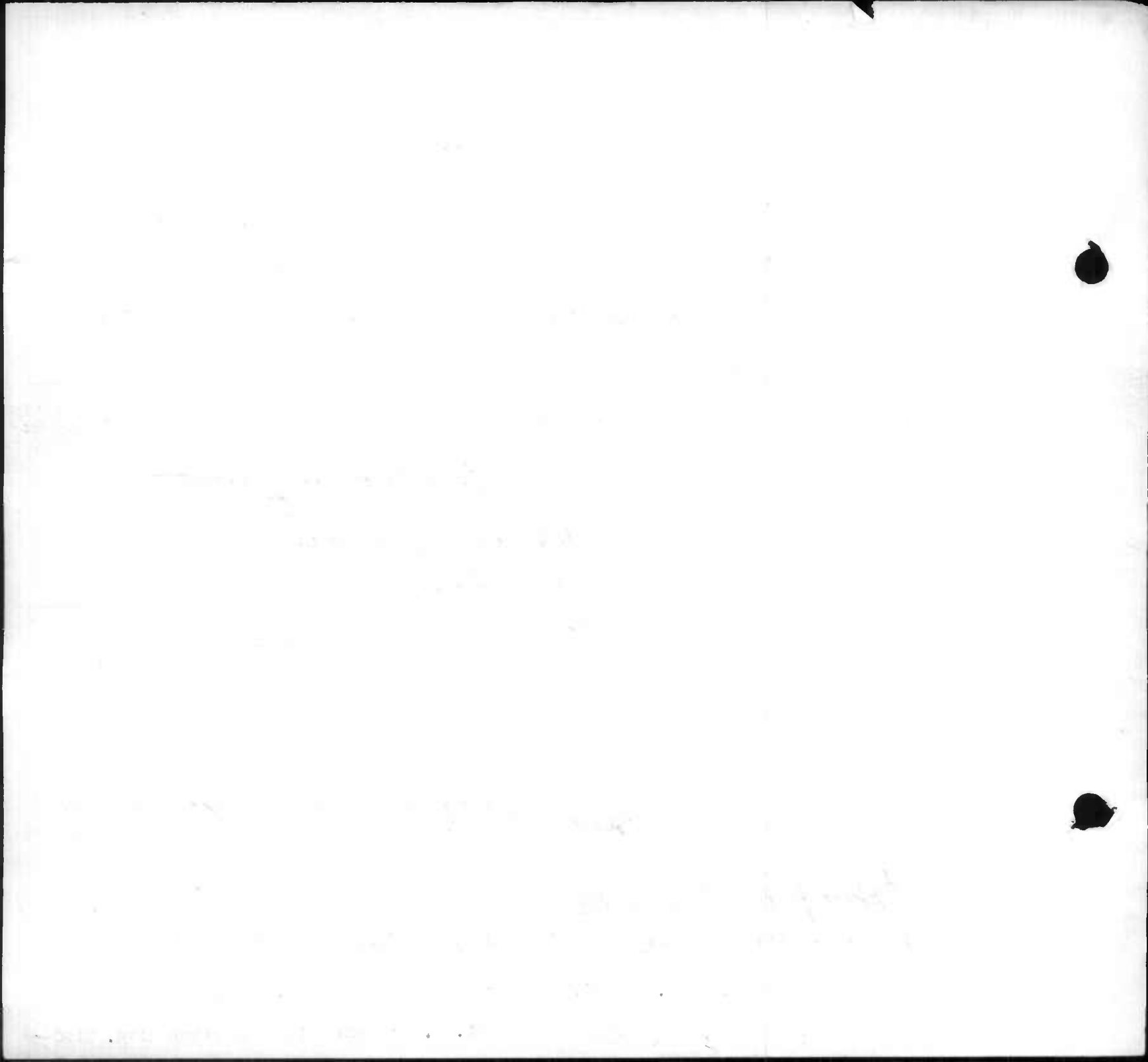
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8788	
BIRTH NO. 1-525 71 8788		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JENSEN, AUGUSTA L. 00			2. DATE AND HOUR OF DEATH 9-15-1971 6:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2801 N. Howard St 21218		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1912	9. AGE (In years last birthday) 59	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) NEY JERSEY	
13. FATHER'S NAME CHARLES ADAMS			12. CITIZEN OF WHAT COUNTRY CITIZEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME BERTHA SHERMAN	
17. INFORMANT Mr. William O. Jensen			ADDRESS Same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Renal and Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-1921 to 9-15-1971 and that (I) (we) last saw the deceased alive on 9-15-1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 9-15-1971		
23C. PHYSICIAN'S NAME (Type) G. NAWIAS M.D.			23D. ADDRESS U.M.H.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/71		24C. NAME of CEMETERY or CREMATORY Morland	
24D. LOCATION Baltimore		24E. ADDRESS Balto. Md.		24F. ADDRESS Balto. Md. 21204	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR William E. Johnson	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-165 71 8789		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 8789	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>O'Brien, Edward</u>		2. DATE AND HOUR OF DEATH <u>9-19-71</u> <u>5⁴⁰</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>New Jersey</u> B. COUNTY <u>V27</u>		C. CITY OR TOWN <u>Eatontown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u> <u>2724 N. Charles St.</u>		E. STREET AND NUMBER <u>508 Washington St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-04</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Elbert O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Mary Madden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>151-18-2430</u>		17. INFORMANT <u>Teresa S. deLaur RN</u>	
18. <u>427.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory Arrest</u> (B) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Uremia</u>		ADDRESS <u>North Charles Gen. Hospital</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary Embolism.</u>					
19A. DATE OF OPERATION <u>8/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Quadrant ulcer</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 29</u> 19 <u>71</u> to <u>Sept. 19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept. 19</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Armando P. Pangilinan MD</u>		23B. DATE SIGNED <u>9/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Armando P. PANGILINAN MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Francis deSales</u>	
24D. LOCATION (City, town, or county) (State) <u>Elka Park, New York</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>	
25C. FUNERAL DIRECTOR <u>Wm. E. Johnson</u>		25D. ADDRESS <u>8521 Loch Raven Blvd. 21204</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8790

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Sharon Queen

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month
Day
Year9
17
71Hour
Minute

11:35 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

3. DATE
PRONOUNCED DEADMonth
Day
Year9
17
71Hour
Minute

11:35 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

2562

6. SEX

female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-2-35

10. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

804 Seagull Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Bacoate

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

stock clerk

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Heath

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

218-32-9034

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Sickle cell crisis during anesthesia

(A) IMMEDIATE CAUSE in the course of hysterectomy
DUE TO, OR AS A CONSEQUENCE OF:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-22-71

24C. NAME OF CEMETERY or CREMATORY

Arbutus

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 20 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

G. Wainwright

ADDRESS

2500 Edmondson Ave.

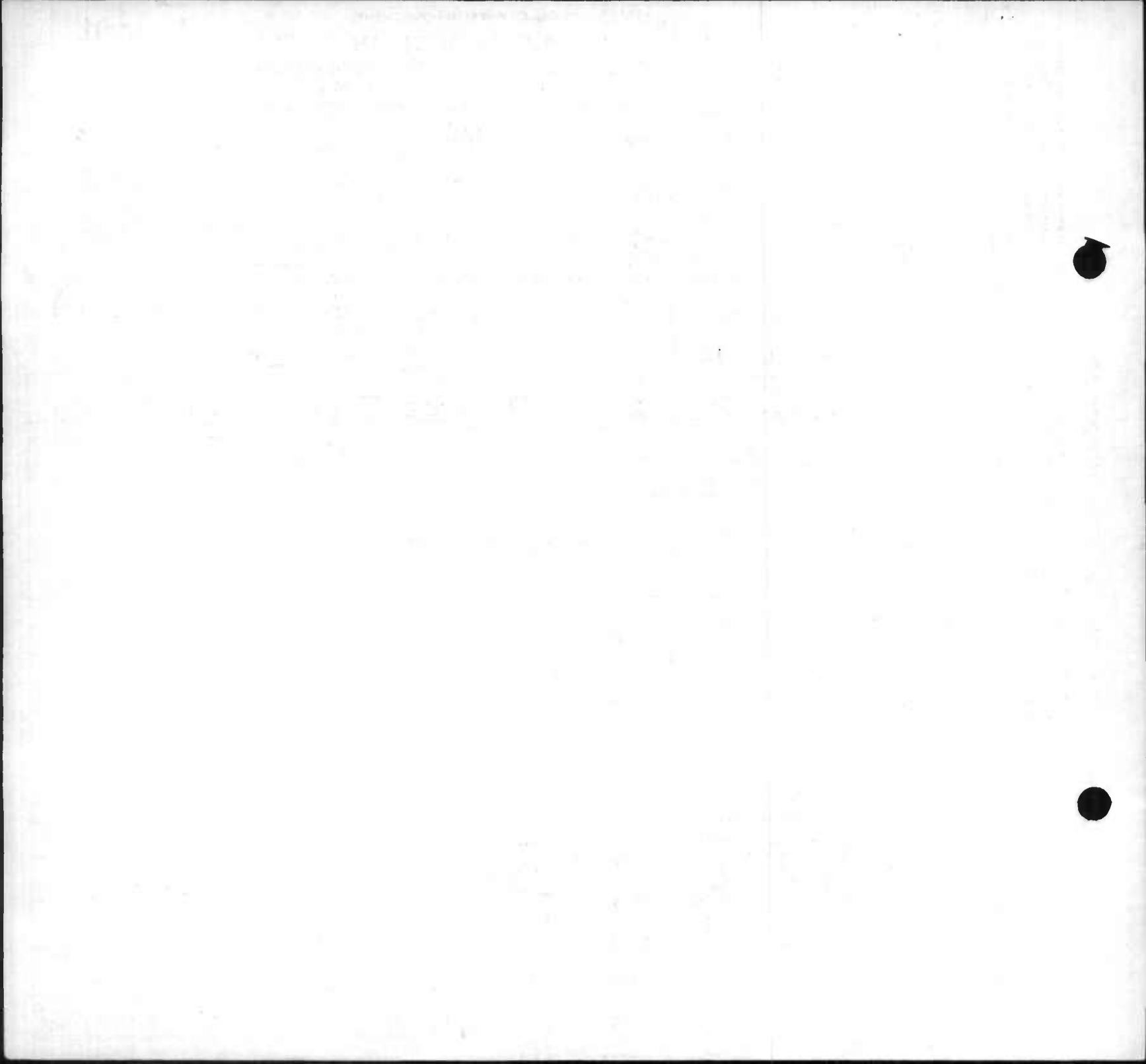
Letter from M.E.'s office
12-1-71 M.H.

Page

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

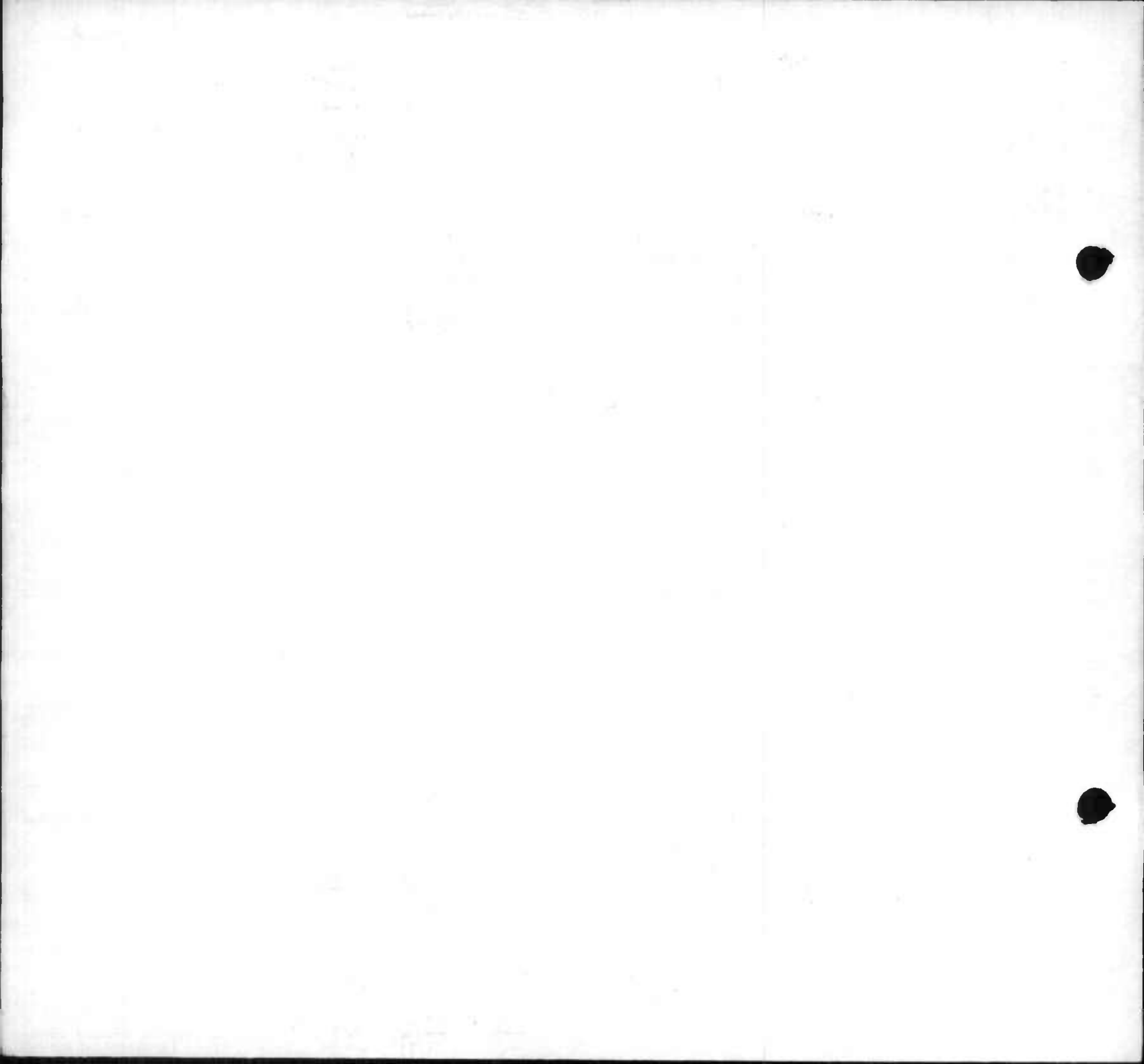
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8791	
B-230 71 8791				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Walter B. Bast				2. DATE AND HOUR OF DEATH 9/16/71 8⁰⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY AA C. CITY OR TOWN Galesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5200			
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/28	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Foreman			10B. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Shady Side MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward L. Bast				14. MOTHER'S MAIDEN NAME Janet Lee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 1952-54		16. SOCIAL SECURITY NO. 217-24-6594		17. INFORMANT Joyce T. Bast, Galesville MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 191X I Astrocystoma of Brain				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 19/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Astrocystoma of Brain		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 6 1971 to Sept 16 1971 that (I) (we) last saw the deceased alive on Sept 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Willard P. Amoss MD				23B. DATE SIGNED 6/16/71		23C. PHYSICIAN'S NAME (Type) Willard P. Amoss MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-19-71		24C. NAME OF CEMETERY OR CREMATORY Woodfield Cemetery		24D. LOCATION (City, town, or county) (State) Galesville AA MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR John E. J. G. 42.0 0 0		25C. FUNERAL DIRECTOR Garphely's Funeral Home, Annapolis, MD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8792</u>	
BIRTH NO. <u>11-635 71 8792</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WALTER L. MARTIN</u>		2. DATE AND HOUR OF DEATH <u>9.16.71</u> <u>2:05 P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME & HOSPITAL</u> <u>BALTIMORE MD. 21231</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND.</u> B. COUNTY <u>2634</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1160 FRAIDLEY WAY. 21205</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.17.08.</u>	9. AGE (In years last birthday) <u>63</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SANITATION DEPT.</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES M. MARTIN.</u>			14. MOTHER'S MAIDEN NAME <u>MARY BURCH.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>No Not Known X</u>		16. SOCIAL SECURITY NO. <u>376-10-3339</u>	17. INFORMANT ADDRESS <u>HOSPITAL CHART.</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>PROFUSE HEMOPTYSIS</u> <u>45 min.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOME (R) LUNG</u> <u>Unknown</u> (C) _____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9.12.71</u> 19__ to <u>9.16.71</u> 19__ that (I) (we) lost saw the deceased alive on <u>9.16.</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Satpal Singh M.D.</u>				23B. DATE SIGNED <u>9.16.71.</u>	
23C. PHYSICIAN'S NAME (Type) <u>Satpal Singh</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/20/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. Frank Beatty & Sons, Inc.</u>			



1
J-525

J-525 71

8793

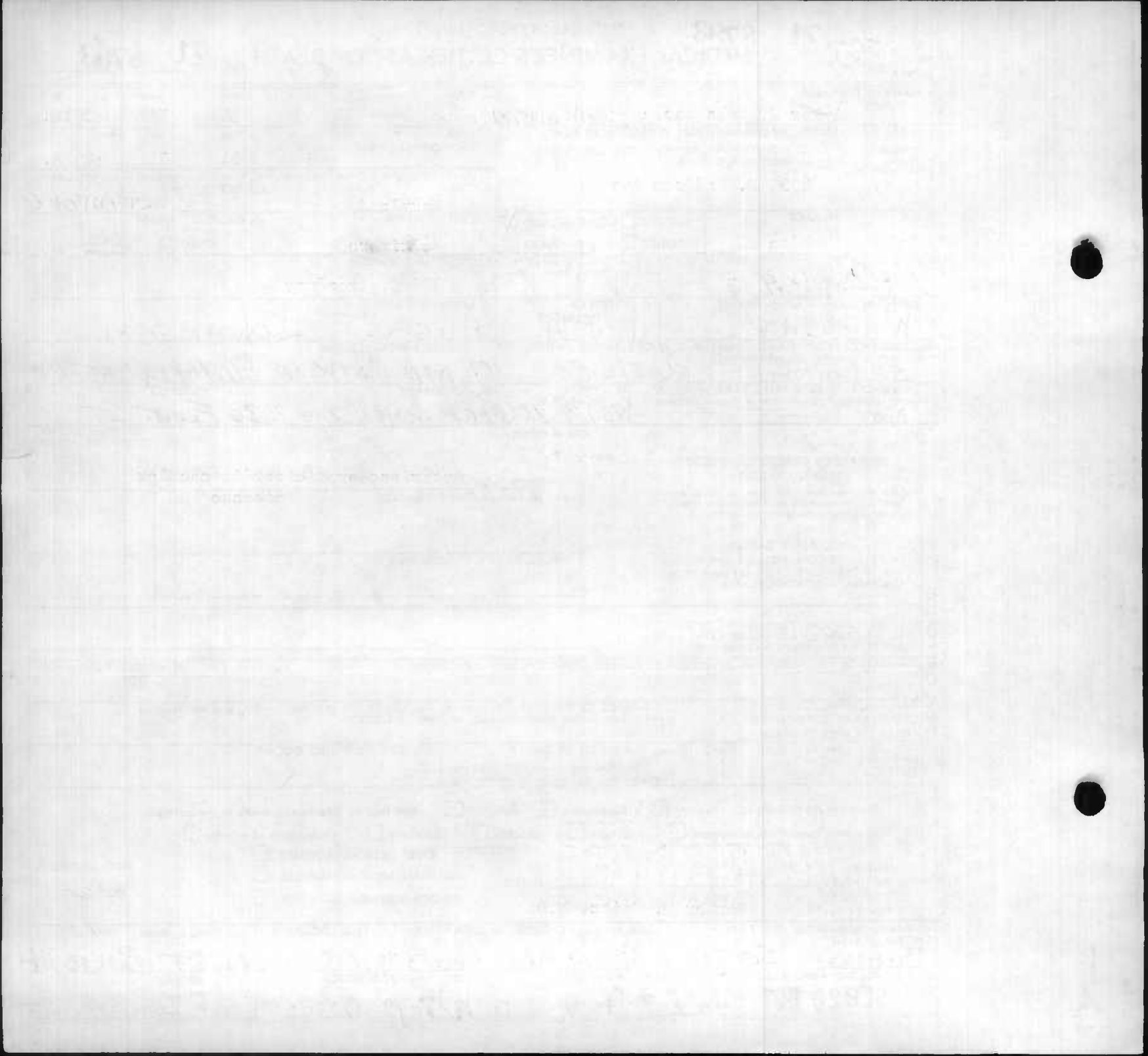
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8793
REG. NO.

BIRTH NO.

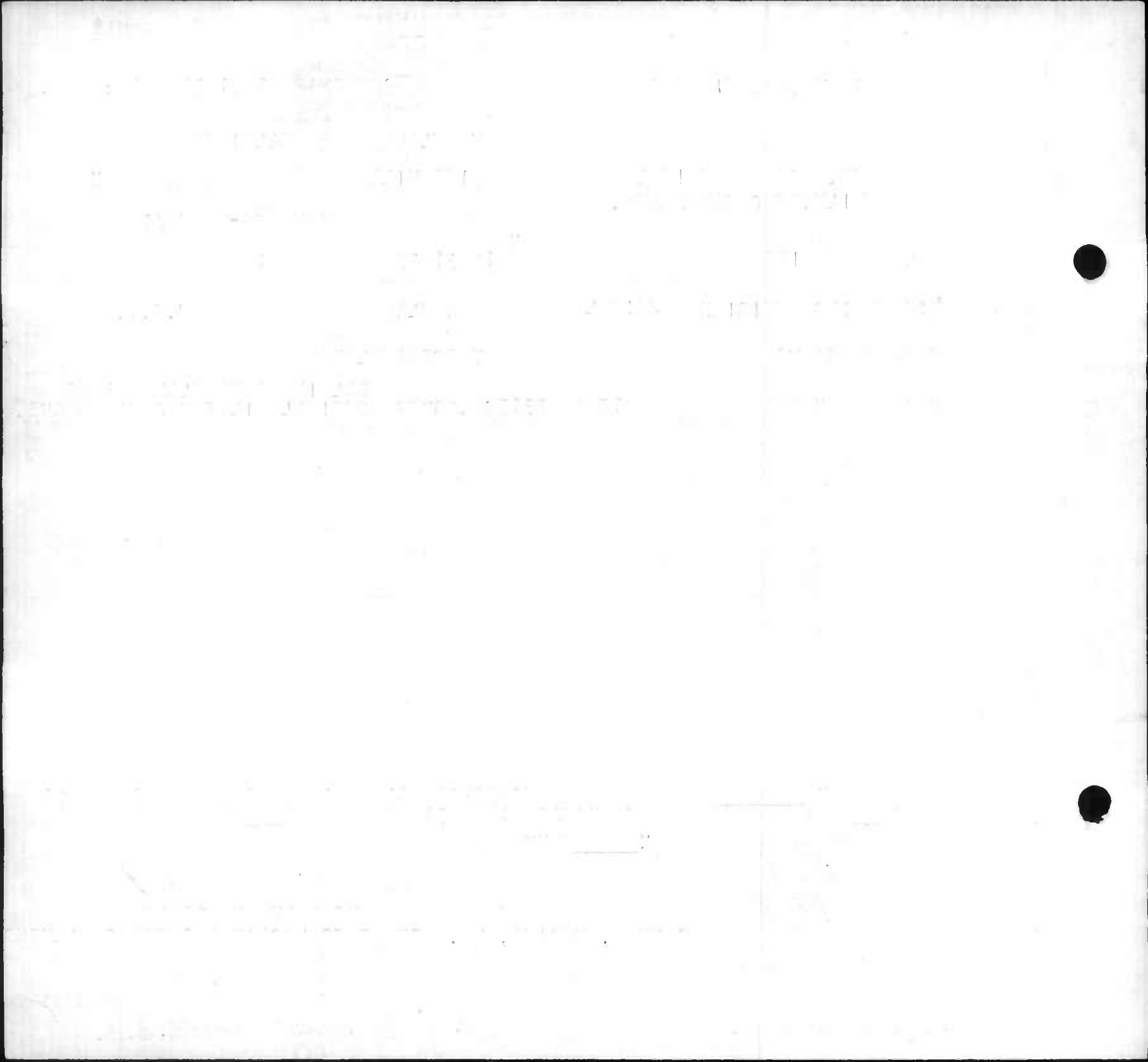
1. NAME OF DECEASED (Type or Print) Anker E. Johannessen - JOHANSEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 14 71 6:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2930 E. Madison Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 14 71 6:20 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 1-20-1904		10. AGE (in years last birthday) 67	
11. BIRTHPLACE (State or foreign country) NORWAY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August JOHANSEN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman	
15. MOTHER'S MAIDEN NAME OLAVA MATKINE EDVARDSDATTER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 439-30-2638		18. INFORMANT ADDRESS PER JOHNSON 1620 Fleet St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE SEPT 18 1971	
24C. NAME OF CEMETERY or CREMATORY Mt Carmel Cemetery		24D. LOCATION (City, town, or county) (State) O'Donnell St BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. J. J. J.	
25C. FUNERAL DIRECTOR		ADDRESS Dippel Bros 1800 E Lombard St	



FUNERAL DIRECTOR: IMPORTANT

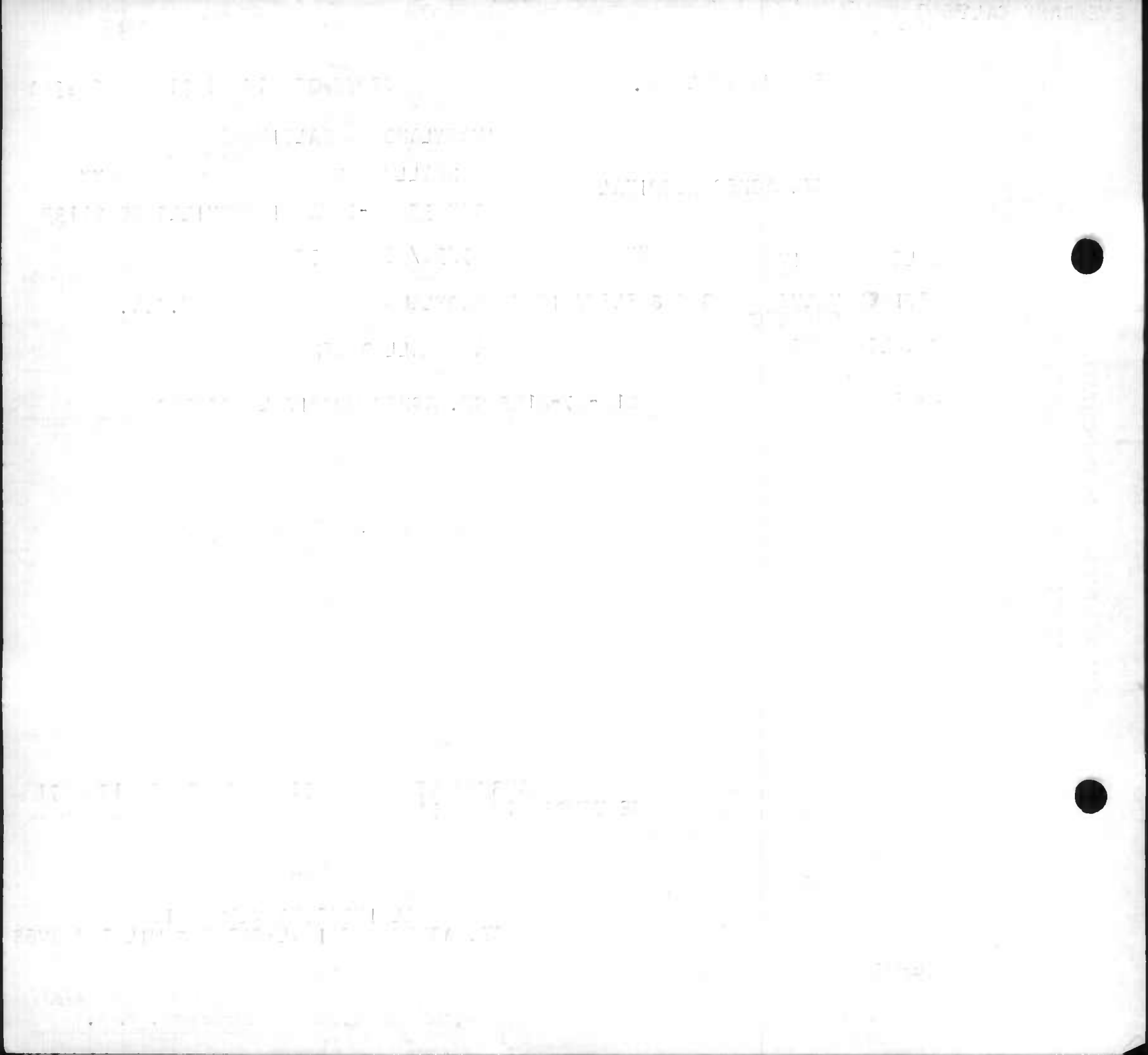
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-610 71 8794		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8794	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GROVE, FRANCIS JOSEPH		2. DATE AND HOUR OF DEATH SEPTEMBER 14, 1971 10:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL 40 WILKENS & CATON AVE.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN PIKESVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER ORCHARD ROAD BOX 256-B RT #7			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 31 29	9. AGE (In years last birthday) 41	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPENSING OPTICIAN OPTICAL		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME STEPHEN GROVE		14. MOTHER'S MAIDEN NAME THERESA BLAZEK	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES KOREA		16. SOCIAL SECURITY NO. 215 24 3317		17. INFORMANT ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca to brain Diagnosis (B) Bronchogenic Carcinoma of the lung (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few months April 1970	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examined)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 13 1971 to SEPTEMBER 14 1971 that (X) (we) last saw the deceased alive on SEPTEMBER 14 1971 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Rahman Karimi		23B. DATE SIGNED 9/17/71		23C. PHYSICIAN'S NAME (Type) Rahman	
23D. ADDRESS RAHMAN, KARIMI, MD. AVE BALTO MD 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/17/1971		24C. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		24D. LOCATION (City, town, or county) (State) Sykesville, Md. Carroll Co.	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 728 Liberty Road ADDRESS 21133 Lofin 7 Myers Funeral Directors, P. A.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

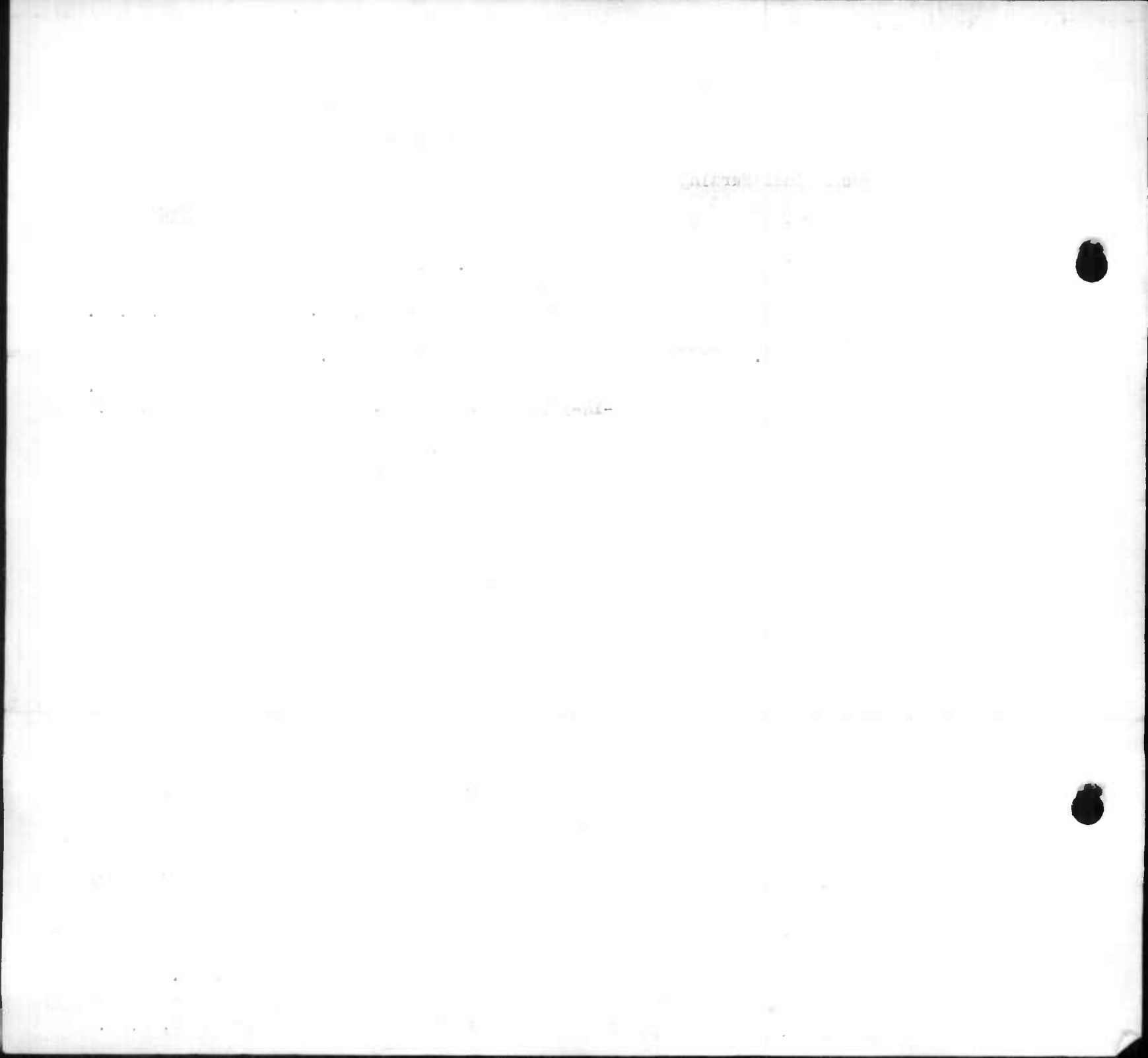
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8795	
BIRTH NO. 8-500 71 8795					
1. NAME OF DECEASED (Type or Print) BOWEN, JAMES L Sr.			2. DATE AND HOUR OF DEATH SEPTEMBER 15, 1971 10:30A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER BOX 359 D-1 MARIOTTSTVILLE RD 21133		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/30/96	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED VALVE OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME CHARLES BOWEN			14. MOTHER'S MAIDEN NAME ANN HALL BOWEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. 212-07-6125		17. INFORMANT ST. AGNES HOSPITAL RECORDS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 162-1-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emboli: suspected (B) Cause of the lung with massive pleural effusion (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Old myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 17 19 71 to SEPTEMBER 15 19 71 that (I) (we) last saw the deceased alive on SEPTEMBER 15 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eitatsu Henzan M.D. DEGREE				23B. DATE SIGNED 9/15/71	
23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN				23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9/18/1971		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park	
24D. LOCATION Burial		24E. CITY, TOWN, OR COUNTY Howard County, Maryland		24F. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 20 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133 Loring Byers Funeral Directors, P. A.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 8796</u>	
V-536 71 8796		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Helen Doris Vanderjort</u>		2. DATE AND HOUR OF DEATH <u>9/15/71 11:55 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Mount Sinai Nursing Home</u> <u>4613 Park Heights Avenue</u> <u>Baltimore, Maryland 21215</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2717</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5304 Maple Avenue 21215</u>	
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26, 1918</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>53</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles W. Hoffmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Anna E. Ireland</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>214-14-9671</u>	
17. INFORMANT <u>Mr. Edwin S. Vandervort Baltimore, Md. 21215</u>		18. CAUSE OF DEATH <u>183.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>12/17/71</u> 19 <u>71</u> to <u>9/15/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/15</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Edward A. Hallins MD</u> DEGREE		23B. DATE SIGNED <u>9/16/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. S. HALLINS MD</u> DEGREE		23D. ADDRESS <u>6000 PARK HTS N Baltimore MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/20/1971</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mount Olive Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	
25C. FUNERAL DIRECTOR <u>Boring Byers Funeral Directors, P. A.</u>		25D. ADDRESS <u>8728 Liberty Road 21133</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8797</u>	
BIRTH NO. <u>B-136 71 8797</u>					
1. NAME OF DECEASED (Type or Print) <u>Minnie L Buffer</u>			2. DATE AND HOUR OF DEATH <u>Sept. 18, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3625 Liberty Hts, Avenue</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3625 Liberty Hts, Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1883</u>	9. AGE (in years last birthday) <u>88</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co, Md</u>
13. FATHER'S NAME <u>David Franklin</u>			14. MOTHER'S MAIDEN NAME <u>Mary Nusbaum</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Catherine Buffer-3625 Liberty Hts, Ave</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>7-12-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral Sclerosis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Heart Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 15 1971</u> to <u>Sept 15 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 15 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel Rubin M.D.</u>			23B. DATE SIGNED <u>9/18/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Samuel Rubin M.D.</u>			23D. ADDRESS <u>203 Butapsco and Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-21-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Armocost Funeral Chapel-4600 Liberty Hts</u>			

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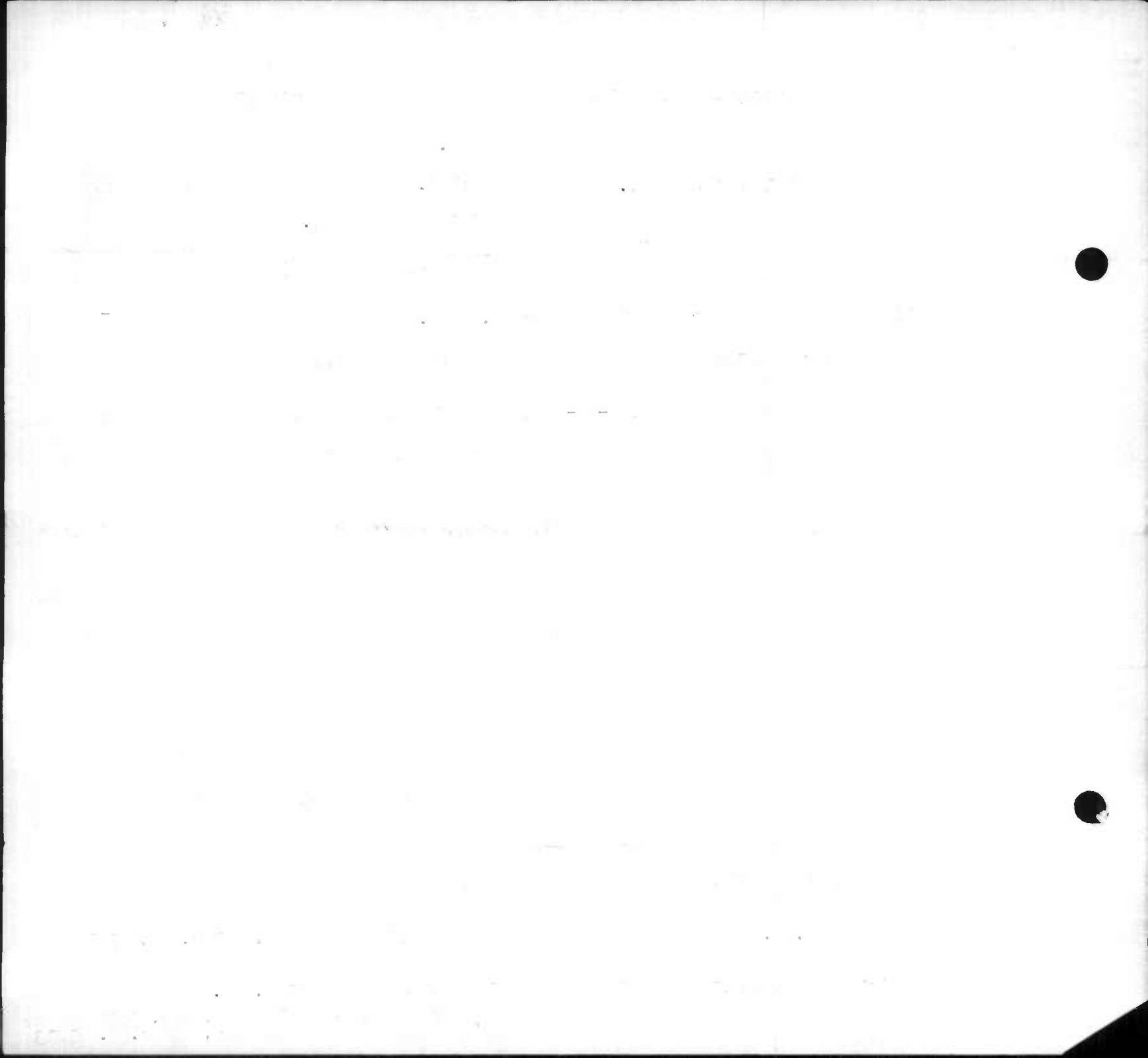
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8798</u>	
BIRTH NO. <u>M-240 71 8798</u>					
1. NAME OF DECEASED (Type or Print) <u>Percy Thomas Moxley</u>		2. DATE AND HOUR OF DEATH <u>9/17/71</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3310 Lyndale Ave.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>841</u>			
		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3310 Lyndale Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/08</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blueprinter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Garden Reproduction Co. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>-</u>	
12. CITIZEN OF WHAT COUNTRY <u>-</u>					
13. FATHER'S NAME <u>James Moxley</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Blackburn</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>228-10-0772</u>		17. INFORMANT <u>Elinor Moxley (wife) same address</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Recurrent Chronic congestive heart failure</u>					
19A. DATE OF OPERATION <u>9/15/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/15/71</u> to <u>9/17/71</u> 19 <u>53</u> that (I) (we) last saw the deceased alive on <u>9/15/71</u> 19 <u>53</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>9/17/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. M. Friedman</u>		23D. ADDRESS <u>5211 Harford Rd. Balto. Md. 21214</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/20/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>E. Naber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Schimmmer Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

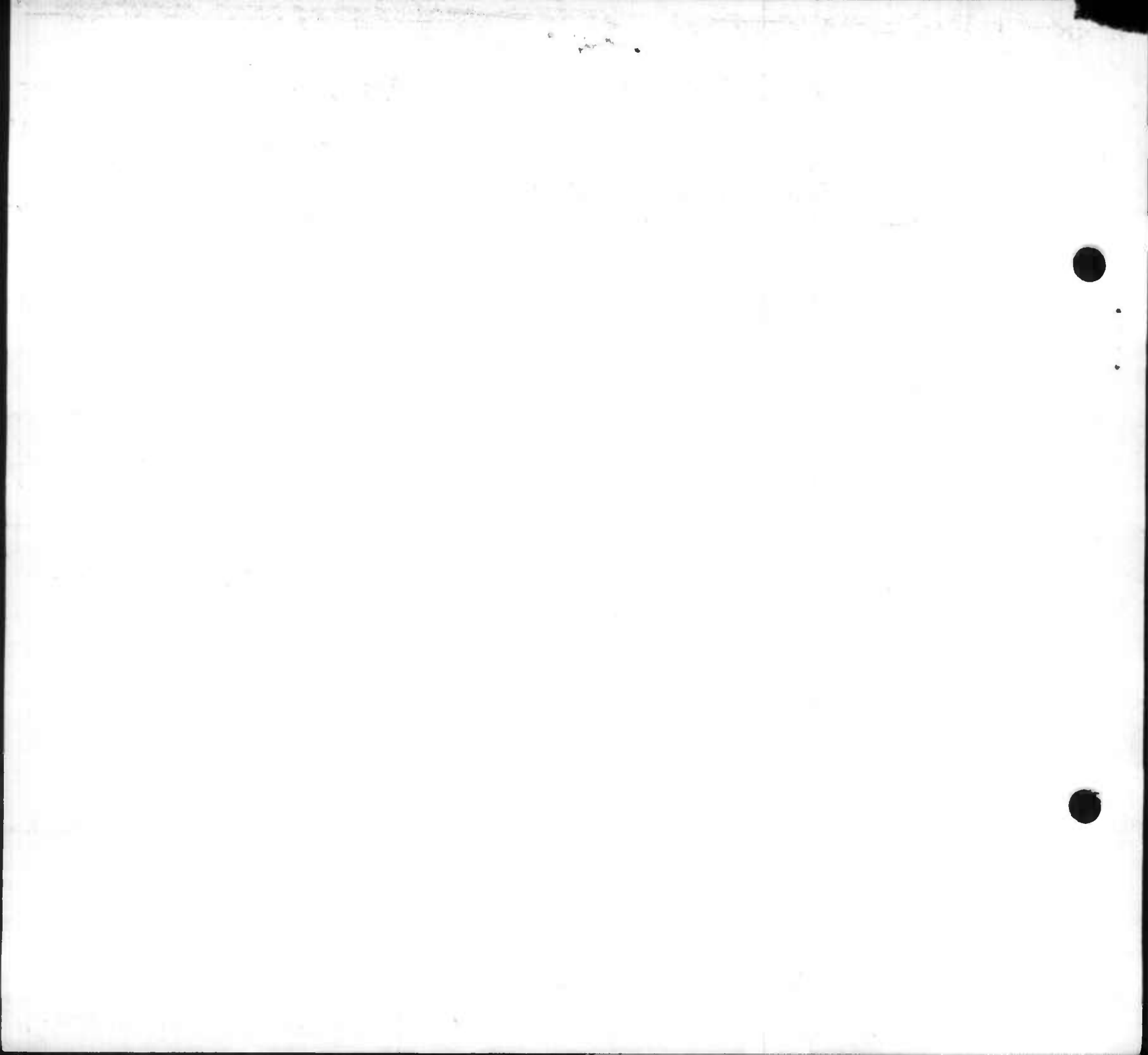
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 8799	
CERTIFICATE OF DEATH					
BIRTH NO. 71 8799		1. NAME OF DECEASED (Type or Print) VOKRAL, MARY			
2. DATE AND HOUR OF DEATH 9/18/71 3:15/A					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE & COUNTY 720 N. PORT ST. 702			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hosp. Broadway + Monument Sts.		C. CITY OR TOWN BALTO., Md. 21205		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/26/79		9. AGE (in years last birthday) 91		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME James Pavlik		14. MOTHER'S MAIDEN NAME BARBARA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-50-2849		17. INFORMANT Lillian B. Owings, dght., above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		? 2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CONCOMITANT CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure		Unknown	
		(C) (Ex & R) Hemiparesis & (Hyp)		2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Involuntarily medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 720 N. Port St.		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9/15/71 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Pt fell down steps		22. I certify that (I) (this hospital) attended the deceased from 9/18 19 71 to 9/18 19 71		that (I) (we) last saw the deceased alive on 9/18 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE DM Haines		23B. DATE SIGNED 9/18/71		23C. PHYSICIAN'S NAME (Type) DM Haines	
23D. ADDRESS 601 N. Broadway		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/71	
24C. NAME OF CEMETERY OR CREMATORY Bohemian Nat. Cem.		24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane	

U.S. CITY OF NEW YORK

FUNERAL DIRECTOR: IMPORTANT

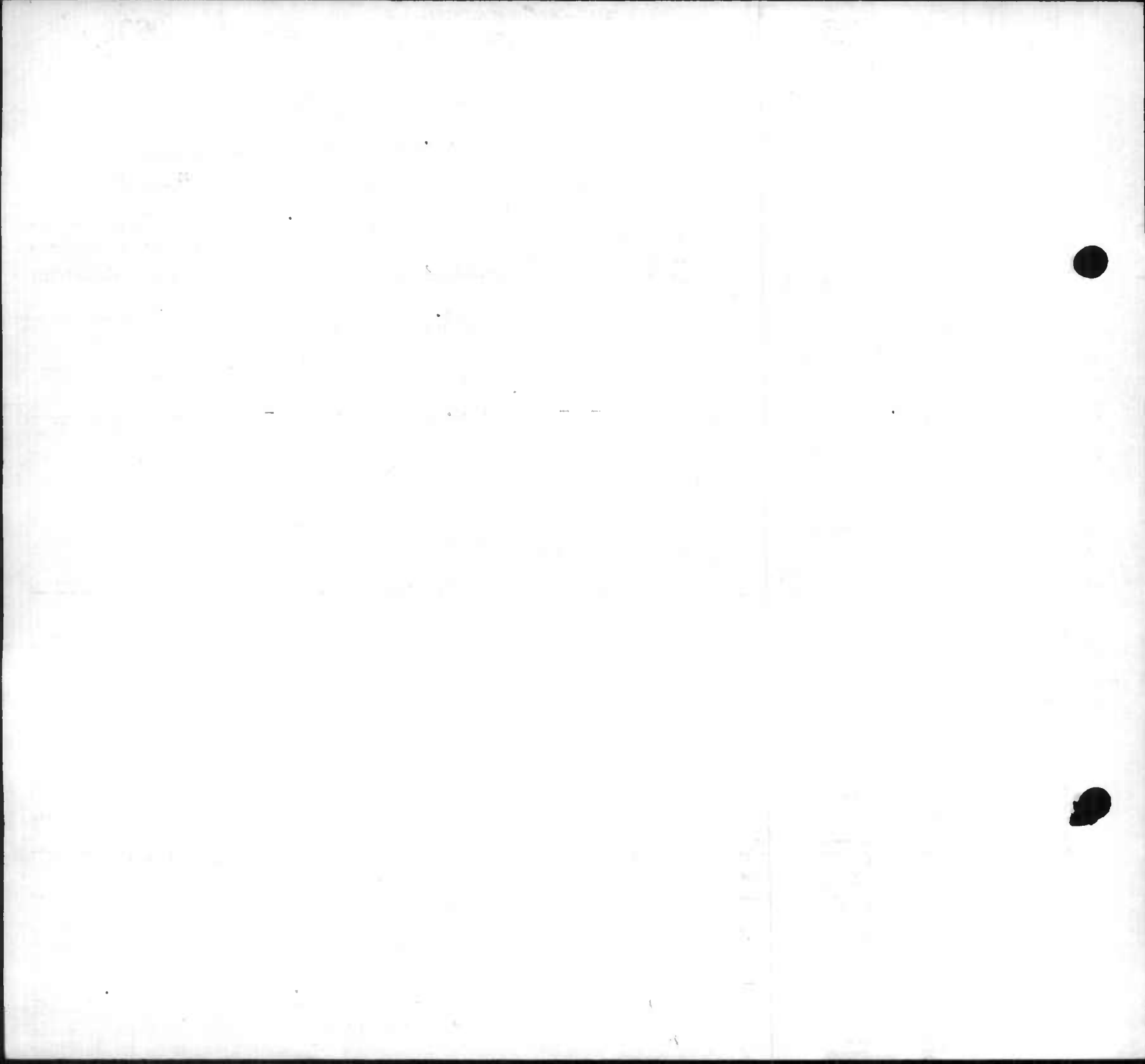
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8800	
BIRTH NO. B-652 71 8800		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) IDA BARNES		2. DATE AND HOUR OF DEATH 9/18/71 @ 2:40 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Harbor View Nursing C. Center 1213		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1908 Breitweitz Ave	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15, 1888
		9. AGE (in years last birthday) 84	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Help		11. BIRTHPLACE (State or foreign country) Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY B. BARNES		14. MOTHER'S MAIDEN NAME MARY E. HARDY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. PL 22-8754	
		17. INFORMANT HENRY CUMMINGS ADDRESS 3372 James St. 21230	
18. 4/21/71 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means injury or complication which caused death.) ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Standstill A.S.C.V.D.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) (B) UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Deep Fractures	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A)		(C) Cerebral - Paralysis	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from 7/23 19 71 to 9/18 19 71 that (I) (we) last saw the deceased alive on 9/2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE K. Kulevskiy MD		23B. DATE SIGNED 9/18/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-21-71	
24C. NAME OF CEMETERY OR CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Paul E. Taylor MD	
		25C. FUNERAL DIRECTOR Ambrose Inc. 1324 Sulphur Springs Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8802</u>	
5-552 71 8802 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>SHEMENSKI, JULIA</u>				2. DATE AND HOUR OF DEATH <u>9-17-71 1:PM</u> <u>1:PM</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u> <u>37</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>808 St. Paul St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-1-06</u> 9. AGE (in years last birthday) <u>65</u> 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>			11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOSEPH SHEMENSKI</u>			14. MOTHER'S MAIDEN NAME <u>KWASY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>223-18-1553</u>	17. INFORMANT <u>MRS.</u> ADDRESS <u>Louise MADEJ 1514 Filbert ST.</u>	
18. <u>244X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrest - post A.I.T.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Myocardema - A.S.H.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Colostomy</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/17/71</u> 19__ to <u>9/17/71</u> 19__ that (I) (we) last saw the deceased alive on <u>9/17/71</u> 19__ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>9-17-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS <u>[Address]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>9/20/71</u>		<u>HOLY CROSS</u>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
<u>Ritely Hwy</u>		<u>BALTIMORE</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>SEP 21 1971</u>		<u>[Signature]</u>		<u>[Signature]</u>	

10/20/71 - operation performed 4/20/71

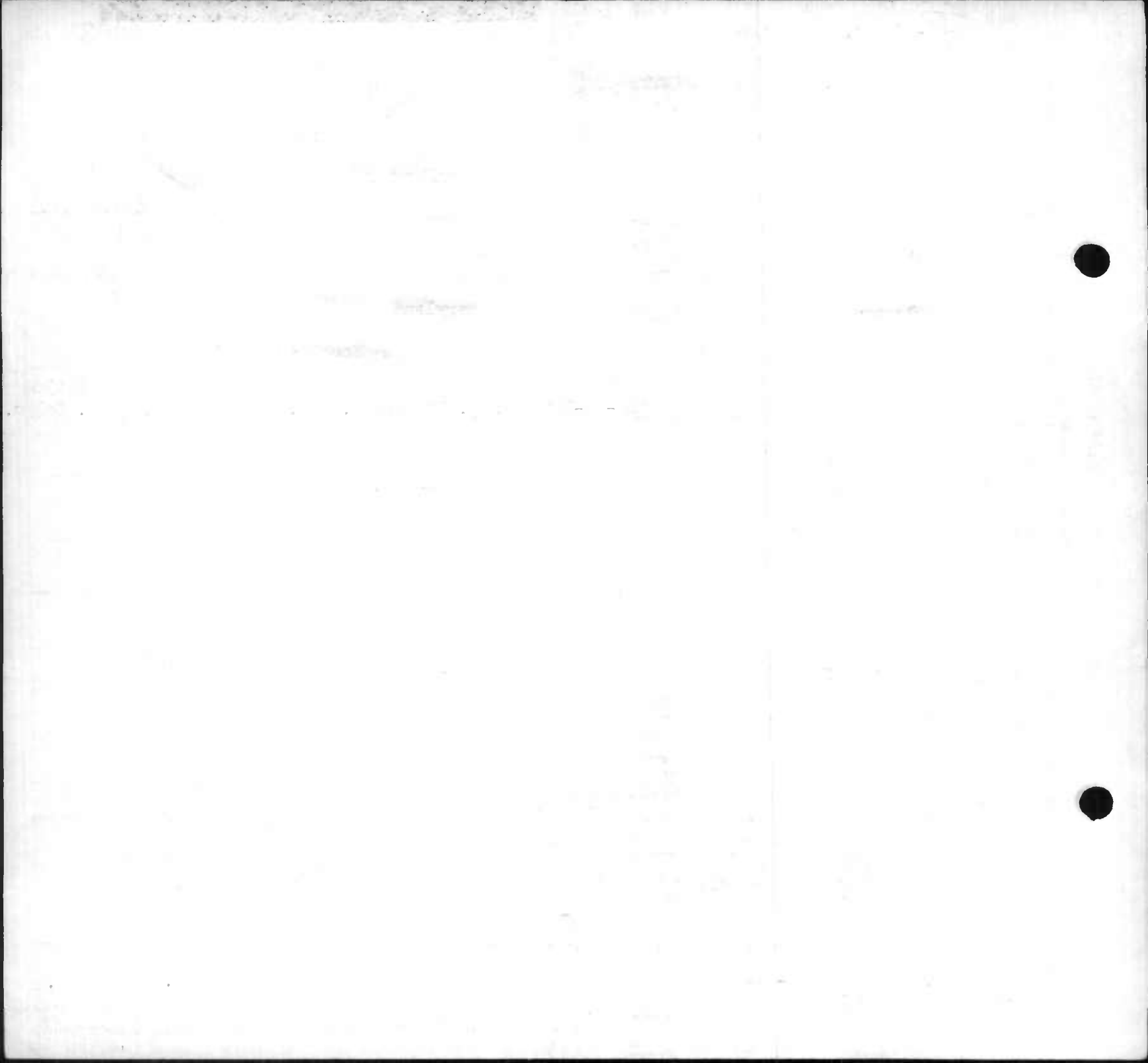
Cause - Intestinal Obstruction

Information from letter from
Mercy Hospital Filed in Bur of Burial
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8803</u>	
BIRTH NO. <u>R-20071 8803</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Randolph William Rouse</u>			2. DATE AND HOUR OF DEATH <u>9/17/71</u> <u>7:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Fullerton</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4244 Cardwell Ave. Balto. Md.</u>		
5. SEX <u>M</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/95</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Wm. Wallace Rouse</u>			14. MOTHER'S MAIDEN NAME <u>Sophie Feuchter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-3126</u>	17. INFORMANT ADDRESS <u>Mrs. Mildred F. Rouse 4244 Cardwell Ave. Balto. 21236</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Pancreas</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/9/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstruction of duodenum</u>		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> 19 <u>71</u> to <u>9/17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Willard P. Amoss M.D.</u> DEGREE				23B. DATE SIGNED <u>9/17/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Willard P. Amoss MD</u> DEGREE				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-21-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto.</u>		24E. STATE <u>Md.</u>		24F. ADDRESS <u>7401 Belair Rd. Balto. 21236</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph Funeral Home</u>	



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D-15271

8804

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

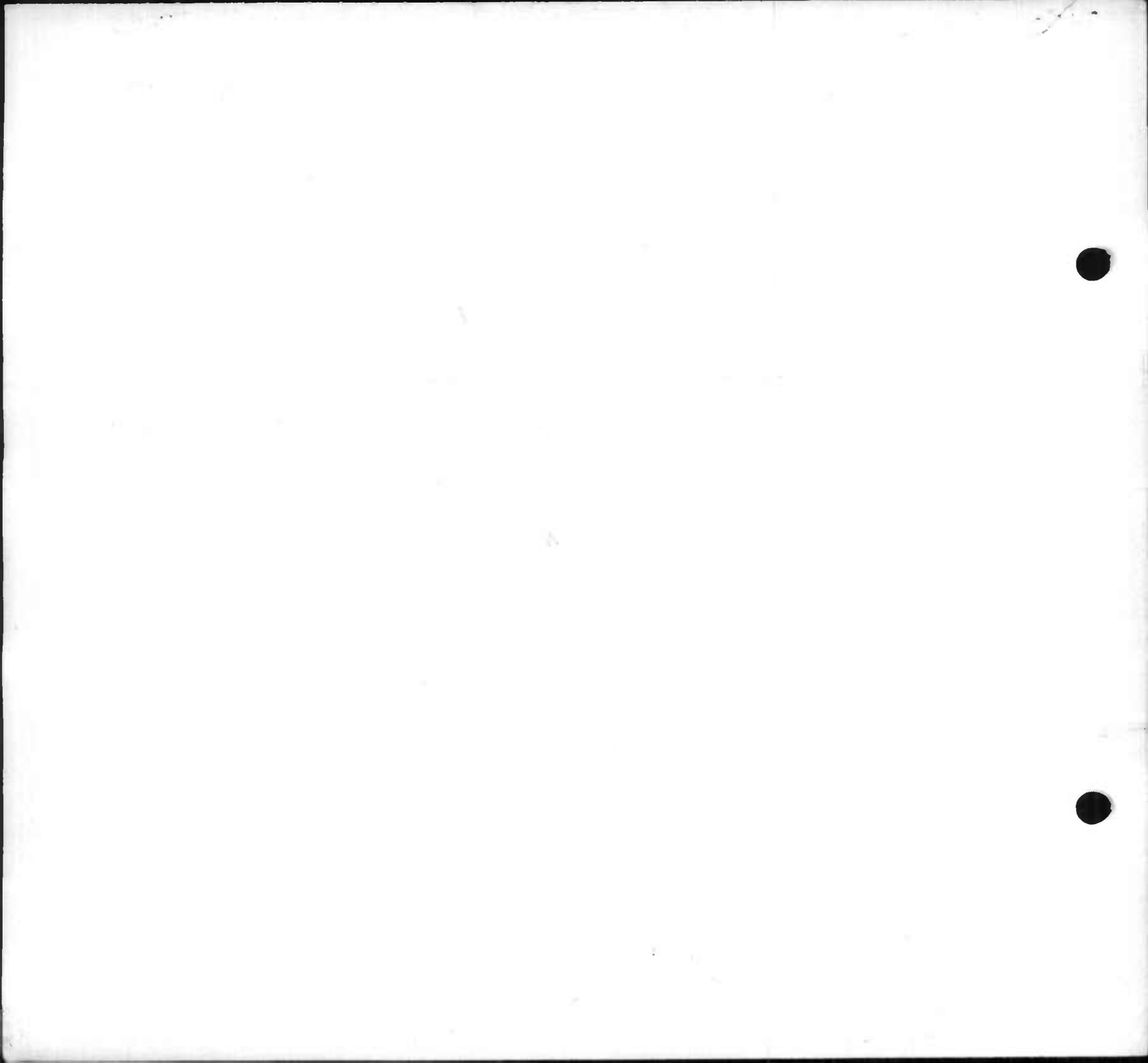
REG. NO. 71 8804

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELFRIEDE SELMA DUBINSKY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 17, 1971		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD NOT IN HOSPITAL OR INSTITUTION 11-1-71 South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 17, 1971		Hour 10:25 P.		M.	
6. SEX Female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2533	
9. DATE OF BIRTH Nov. 26, 1912		10. AGE (In years last birthday) 58		11. BIRTHPLACE (State or foreign country) Berlin, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Victoria Elizabeth Luzack		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 205 30 1909		18. INFORMANT Bernard E. Dubinsky (same)		ADDRESS			
19. 3-20-1		CAUSE OF DEATH Purulent meningitis (Pneumococcal)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Purulent meningitis DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-18-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/1971		24C. NAME of CEMETERY or CREMATORY Arlington National Cem.		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy., Baltimore, Md. 21223	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

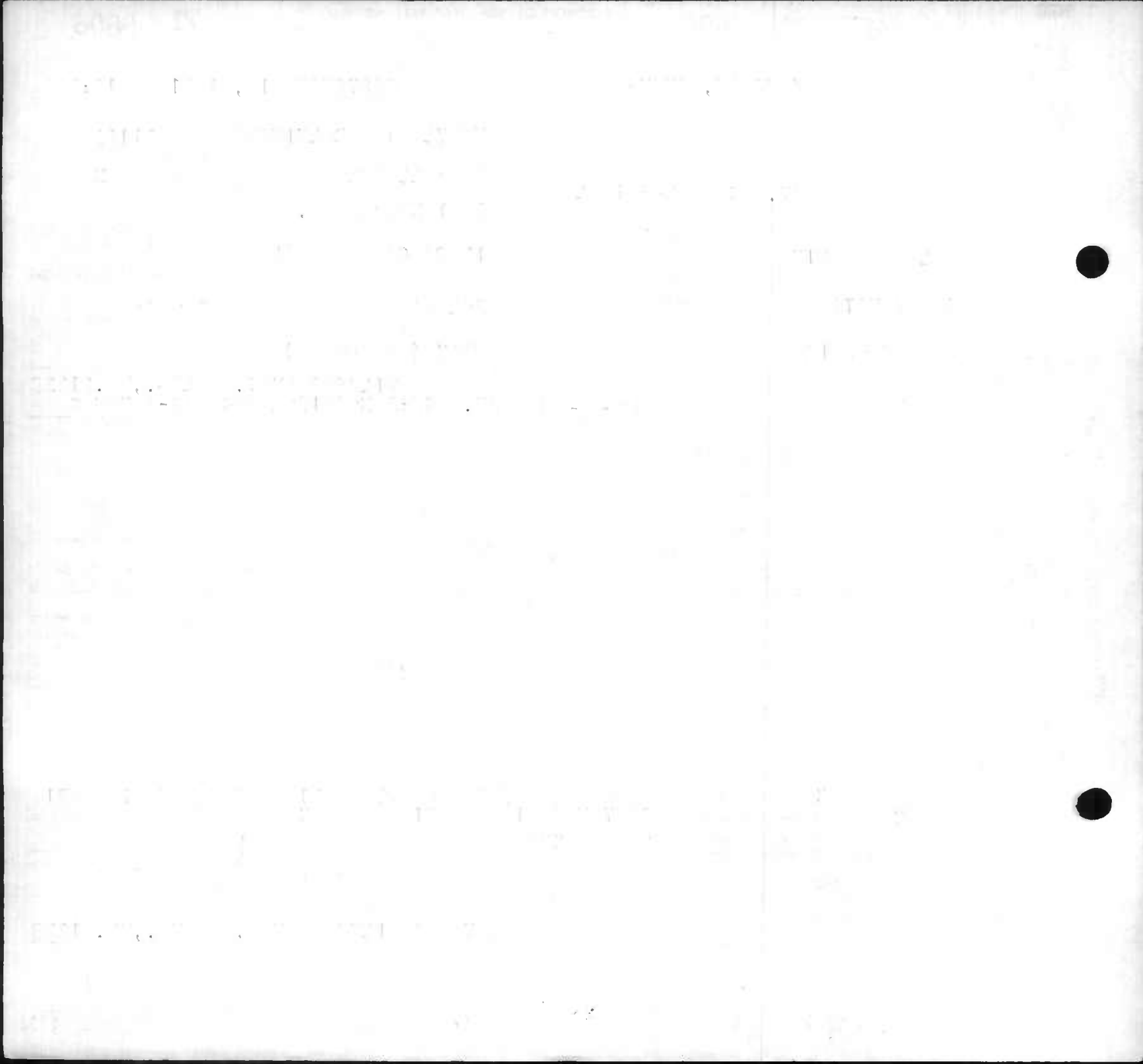
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>71 8805</u></p>	
<p>BIRTH NO.</p> <p><u>S-140 71 8805</u></p>		<p>1. NAME OF DECEASED (Type or Print) <u>MRS. DOROTHY B. SEVIL</u></p>	
<p>2. DATE AND HOUR OF DEATH</p> <p><u>4:20 AM 9/20/71</u></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p><u>DON SECOURS HOSPITAL</u></p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>MD.</u> B. COUNTY <u>21228 BALTO 5300</u></p>		<p>5. CITY OR TOWN <u>BALTIMORE</u></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><u>DON SECOURS HOSPITAL</u></p>		<p>E. STREET AND NUMBER <u>18 BEAUMONT AVE.</u> <u>2025 W. BALTIMORE STS.</u></p>	
<p>6. SEX</p> <p><u>FEMALE</u></p>	<p>7. RACE</p> <p><u>WHITE</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p><u>6/3/23</u></p>
<p>9. AGE (In years last birthday) <u>48</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>HOUSEWIFE</u></p>	<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>DEL</u></p>
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME</p> <p><u>? BRODOWSKI ?</u></p>	<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Anna Stacia</u></p>
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p> <p><u>221-14-5425</u></p>	<p>17. INFORMANT <u>Howell Sevil - Same</u></p> <p>ADDRESS</p>
<p>18. CAUSE OF DEATH</p> <p><u>577.01</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES e.g.</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>HEMORRHAGIC PANCREATITIS.</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>4 days</u></p>	
<p>19A. DATE OF OPERATION</p> <p><u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p><u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>9/16/1971</u> 19 to <u>9/20/71</u> 19 that (I) (we) last saw the deceased alive on <u>9/19/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p><u>Yunyong Yungyong</u></p>		<p>23B. DATE SIGNED</p> <p><u>9/20/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>DR. YUNYONG YUNYONGYING</u></p>		<p>23D. ADDRESS</p> <p><u>DON SECOURS HOSPITAL</u></p>	
<p>24A. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>24B. DATE</p> <p><u>9-22-71</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p><u>Odd Fellows Cem.</u></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Smyrna, Del.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>SEP 21 1971</u></p>		<p>25B. NAME OF REGISTRAR</p> <p><u>Robert E. H. B. Co.</u></p>	
<p>25C. FUNERAL DIRECTOR</p> <p><u>J. H. C. M. Inc.</u></p>		<p>ADDRESS</p> <p><u>6415 Belair Rd</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

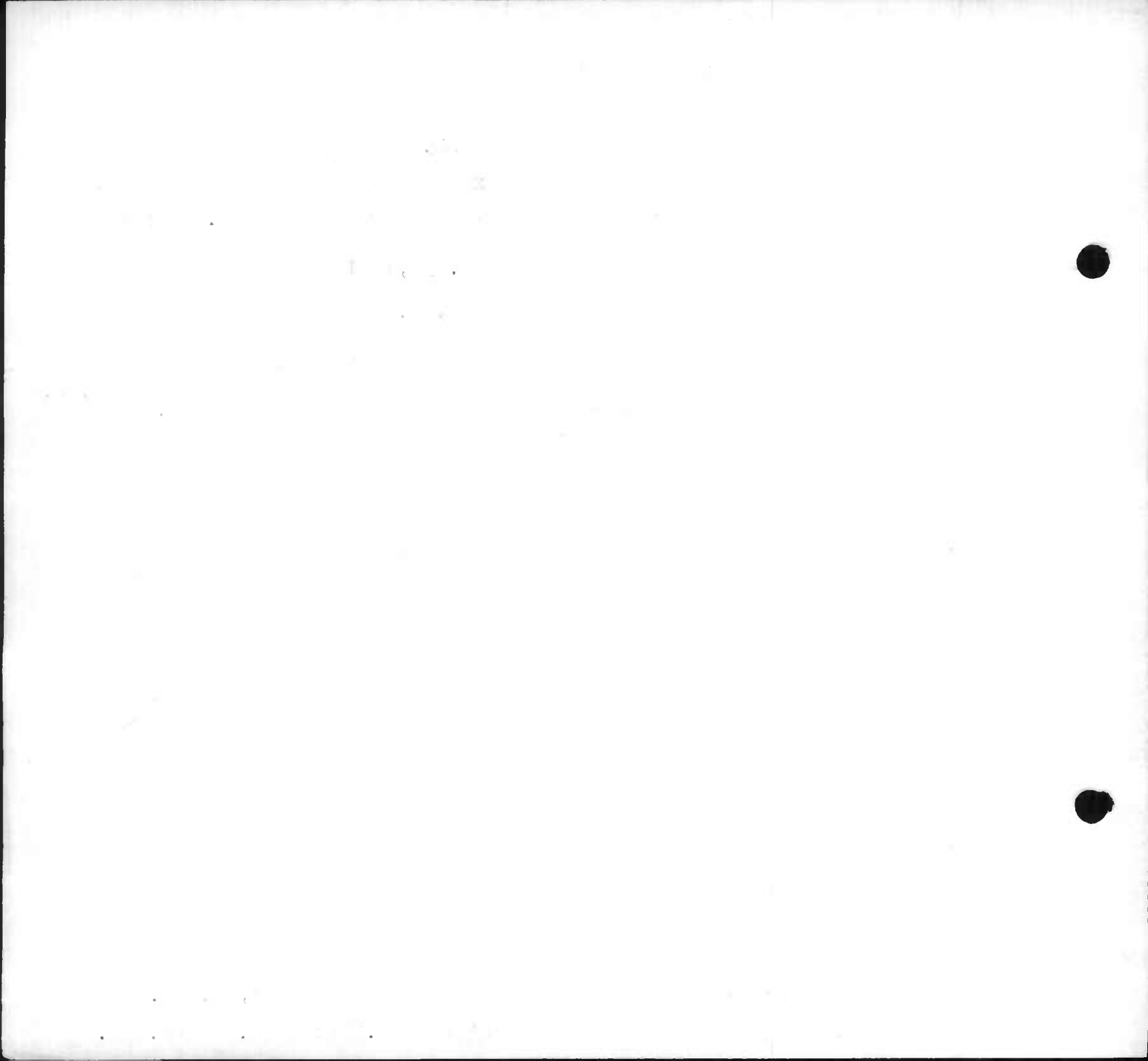
BIRTH NO. K-615 71 8806		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8806	
1. NAME OF DECEASED (Type or Print) KRUPNIK, STEVE			2. DATE AND HOUR OF DEATH SEPTEMBER 18, 1971 11:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21133 5300 C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3801 HENDON RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 09 06	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION			10B. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN KRUPNIK		
14. MOTHER'S MAIDEN NAME MARY (unknown) KRUPNIK			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 193-09-0915			17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH <i>Cardiogenic shock.</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute coronary thrombosis 1 hr.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Distended, cordon dis.</i> 5 yrs. (C) <i>Thromb.</i> <i>Infarction right temporal 12 days</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10'					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1 Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 07 19 71 to SEPTEMBER 18 19 71 that (X) (we) lost saw the deceased alive on SEPTEMBER 18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> M.D. DEGREE			23B. DATE SIGNED 9/18/71		
23C. PHYSICIAN'S NAME (Type) <i>Jose After, M.D.</i>			23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE Sept. 21, 1971		
24C. NAME OF CEMETERY or CREMATORY Holy Family Cemetery			24D. LOCATION (City, town, or county) Randallstown Baltimore Maryland		
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971			25B. NAME OF REGISTRAR <i>[Signature]</i>		
25C. FUNERAL DIRECTOR Lois Byers			25D. ADDRESS 3728 Liberty Rd. Randallstown Maryland 21133		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

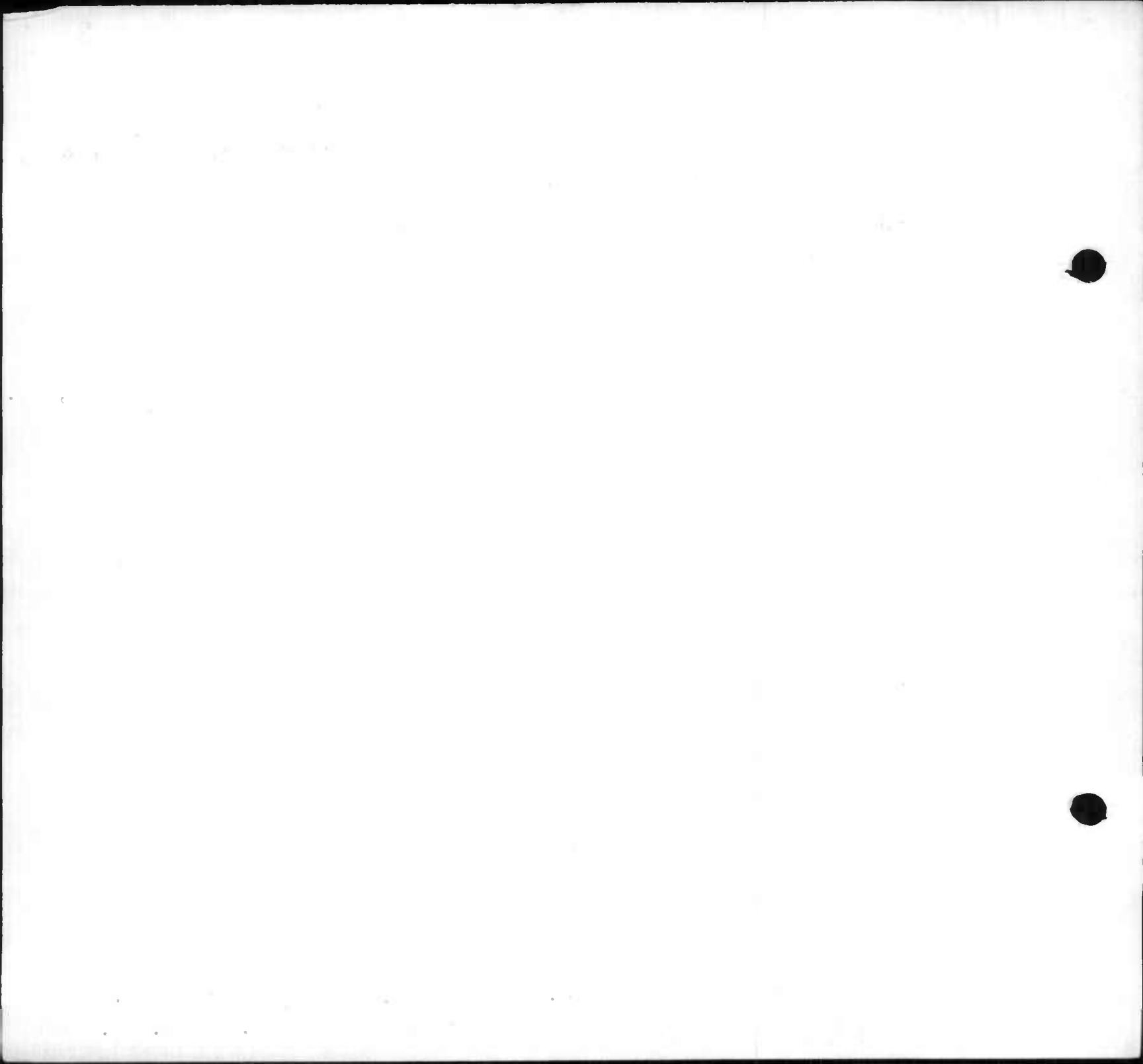
M-240 71 8807		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8807	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Fay Ralston Maxwell</u>		2. DATE AND HOUR OF DEATH <u>9-18-71</u> <u>12:45</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND General Hospital</u> <u>48</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>West Virginia</u> B. COUNTY <u>Clarksburg</u> C. CITY OR TOWN <u>Clarksburg</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>4028 Balford Rd.</u> Rt. <u>3</u> Box <u>440</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1901</u>	9. AGE (in years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Renic Ralston</u>		14. MOTHER'S MAIDEN NAME <u>Melinda Harden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-48-4188</u>		17. INFORMANT <u>Davis Funeral Home</u> ADDRESS <u>Clarksburg, W. Va. 443 W. Pike St</u>	
18. <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ischemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarction</u> (C) <u>23 days</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/18/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>8/26</u> 19 <u>71</u> to <u>9/18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/18/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <u>Johanny T. Tygo M.D.</u>		23B. DATE SIGNED <u>9/18/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Johanny T. Tygo M.D.</u>	
23D. ADDRESS <u>Clarksburg, W. Va.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>9/18/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Clarksburg, W. Va.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-352 71 8808 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		<div style="display: flex; align-items: center;"> X REG. NO. 71 8808 </div>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>MRS ALICE PRICE Stinchcomb</u>		2. DATE AND HOUR OF DEATH <u>9/18/71</u> <u>4.16</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY of MARYLAND Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>SOMERSET</u> <u>6900</u> C. CITY OR TOWN <u>MARION</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Rt 1</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/13</u>	9. AGE (in years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
13. FATHER'S NAME <u>GEORGE L. PRICE</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Chason</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>F. Philip Stinchcomb Route #1</u>	
18. <u>7/12/13</u>		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
		(A) IMMEDIATE CAUSE <u>Left ventricular aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Old Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Severe coronary arteriosclerosis</u>			
		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Probable thrombosis of left middle cerebral artery</u>			
19A. DATE OF OPERATION <u>9/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Left ventricular aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 21</u> 19 <u>71</u> to <u>September 18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>September 18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. S. Florian, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/18/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN M. FLORIAN, M.D.</u>		23D. ADDRESS <u>UNIVERSITY Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-21-71</u>	24C. NAME of CEMETERY or CREMATORY <u>Belair Mem. Gardens Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Belair, Harford, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Nuck Inc. Balto. Md. 21214</u>	



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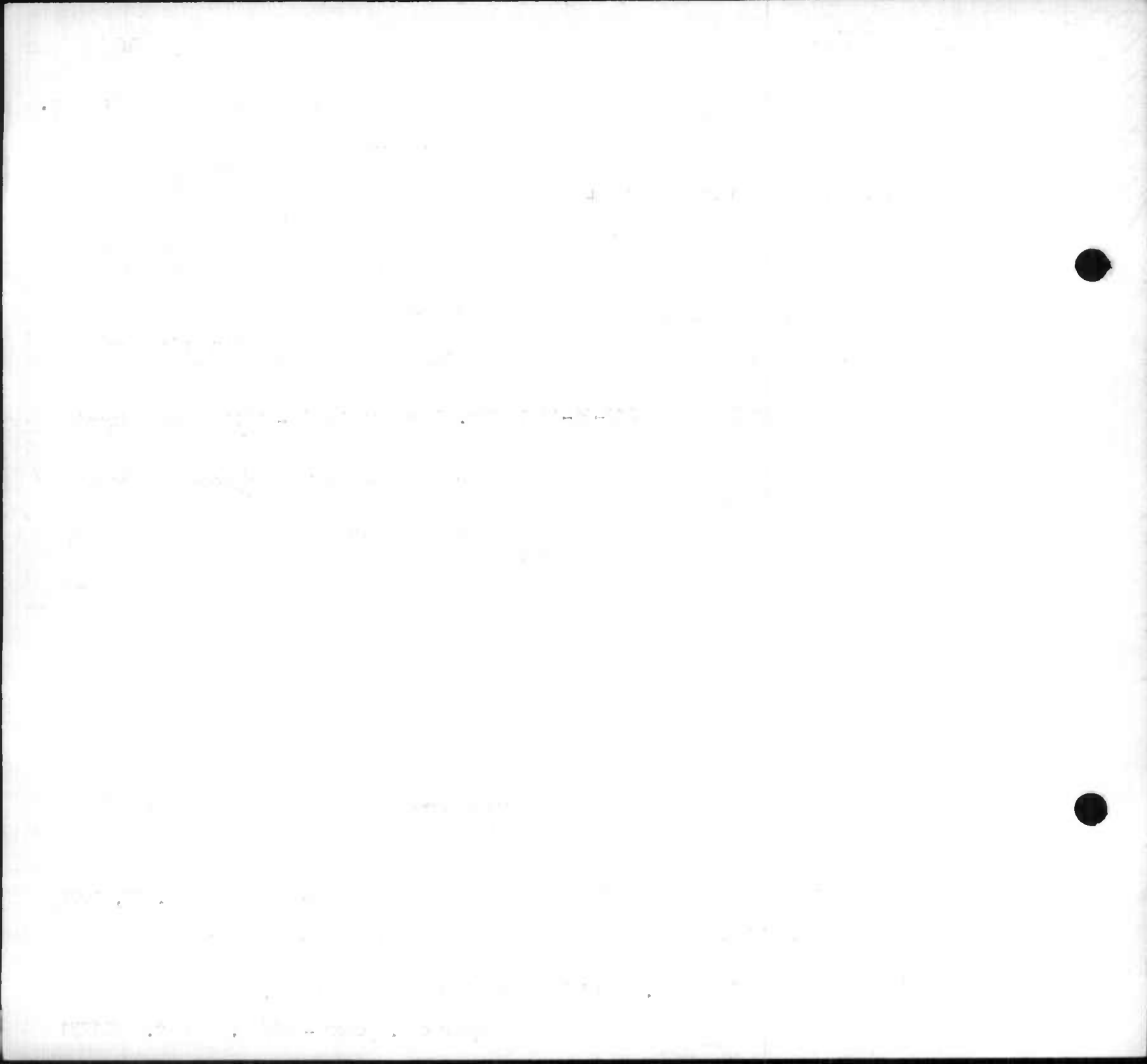
71 8809		BALTIMORE CITY HEALTH DEPARTMENT		71 8809	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) PAUL SIMONS			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9- 18 71 M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital			3. DATE PRONOUNCED DEAD Month Day Year Hour September 18, 1971 10:40 P.M.		
6. SEX Male			5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1504		
7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9/9/49		10. AGE (In years lost birthday) 22		E. STREET AND NUMBER 2004 N. Payson Street	
11. BIRTH PLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Simons	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		14B. KIND OF BUSINESS OR INDUSTRY Garage		15. MOTHER'S MAIDEN NAME Louise Simons	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-50-3701		18. INFORMANT ADDRESS Henry Simons - 2004 N. Payson St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2004 N. Payson Street 1504	
22D. TIME OF INJURY (APPROX.) 9-18-71 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 19, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/71		24C. NAME OF CEMETERY or CREMATORY Pleasant Rest	
24D. LOCATION (City, town, or county) (State) Towson, Balt. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR			
Updell Chaturan		1701 7th Culler St Baltimore			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>R-32271 8810</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8810</p>	
<p>BIRTH NO. Anthony Ratajczak</p>		<p>2. DATE AND HOUR OF DEATH 9/19/71 5:50 P.M.</p>	
<p>1. NAME OF DECEASED (Type or Print) Ratajczak Anthony</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</p> <p>A. STATE MARYLAND</p> <p>B. COUNTY 104</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL</p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>C. CITY OR TOWN Baltimore, MD 21224</p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 2514 Hudson St.</p>	
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 12/15/95</p> <p>9. AGE (In years last birthday) 75</p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Steel</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTIMORE</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME RATAJCAK, THOMAS</p>		<p>14. MOTHER'S MAIDEN NAME Maryanna Dziaduszek</p> <p>DZIADUCEK, MARIAN</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES World War I</p>		<p>16. SOCIAL SECURITY NO. 215-09-4881</p>	
<p>17. INFORMANT Mrs. Anna Ratajczak - 2514 Hudson Street</p>		<p>ADDRESS</p>	
<p>18. 43341 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE Cerebral artery occlusion days</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Arteriosclerosis Years</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from September 12, 1971 to September 19, 1971 that (I) (we) last saw the deceased alive on September 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Robert C. Bast Jr. MD</p>		<p>23B. DATE SIGNED Sept. 19, 1971</p>	
<p>23C. PHYSICIAN'S NAME (Type) ROBERT C. BAST, JR., MD</p>		<p>23D. ADDRESS JOHNS HOPKINS HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 9/23/71</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery</p>		<p>24D. LOCATION (City, town, or county) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971</p>		<p>25B. NAME OF REGISTRAR George A. Weber</p>	
<p>25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231</p>		<p>ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8811	
B-530 71 8811				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ROMAINE BOND		2. DATE AND HOUR OF DEATH Sept 18, 1971 9:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL, 730 ASHBURTON ST, BALTIMORE, MD 21216.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 1602			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/15/24		9. AGE (In years last birthday) 46		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Margaret Parker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 218-22-6802		17. INFORMANT Mr. Benjamin Bond-1315 W. Mosher Street	
18. 30321		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC ALCOHOLISM (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two weeks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/7/1971 to 9/18/1971 that (I) (we) last saw the deceased alive on 9/18/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Azad Cader		23B. DATE SIGNED Sept 18, 1971		23C. PHYSICIAN'S NAME (Type) AZAD CADER	
23D. ADDRESS LUTHERAN HOSPITAL, BALTO, MD 21216.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE RECEIVED BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mary-Elizabeth Law	
25D. ADDRESS 802 Madison Avenue					

24

11/12/54

11/12/54

FUNERAL DIRECTOR: IMPORTANT

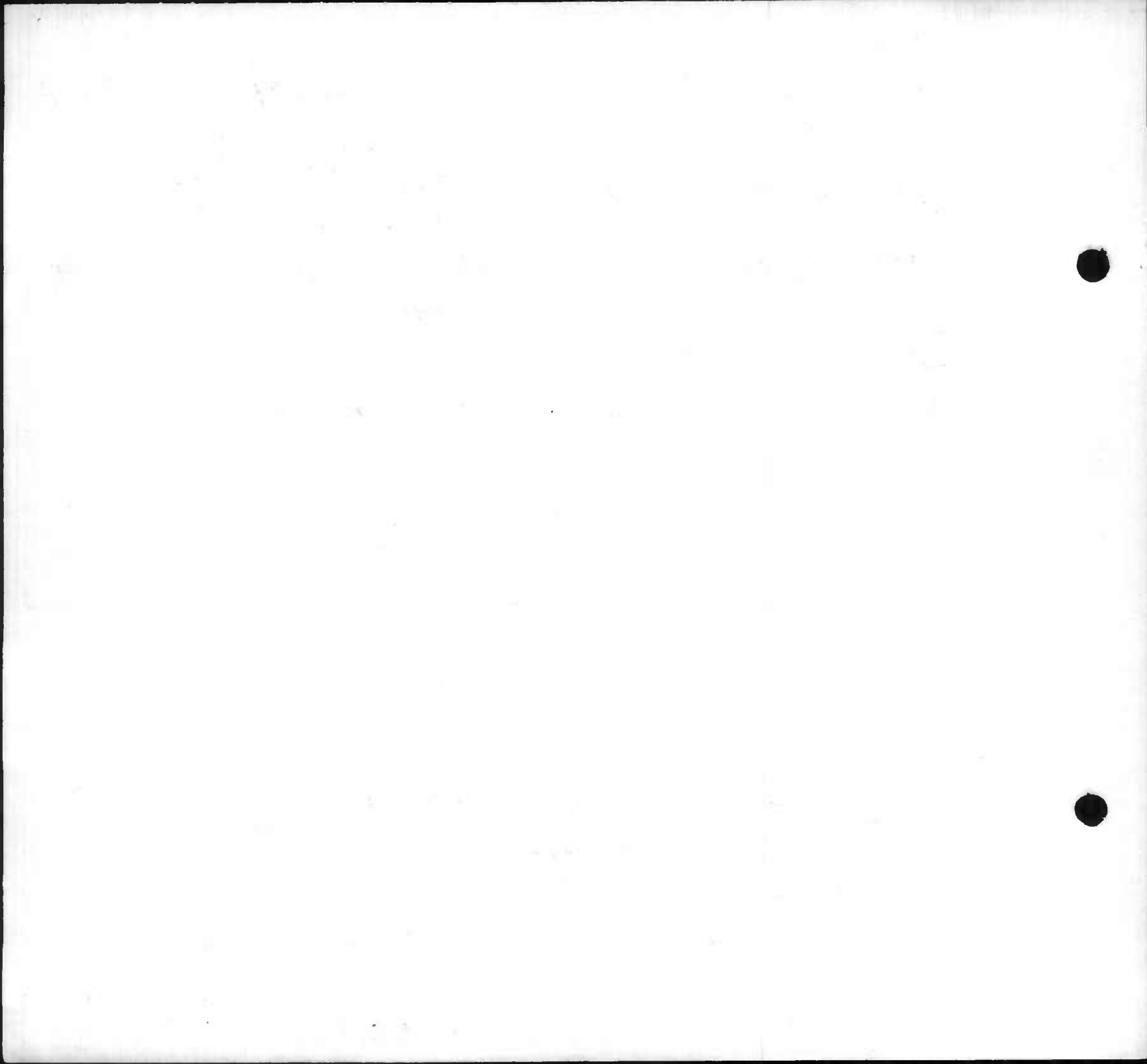
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9812</u>	
<p>BIRTH NO. <u>S-530 71 9812</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>SMITH BABY GIRL TWIN B</u></p>		<p>2. DATE AND HOUR OF DEATH <u>SEPTEMBER 14 1971 4:40 A.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1403</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1830 McCulloh Street</u></p>			
<p>5. SEX <u>FEMALE</u></p>	<p>6. RACE <u>NEGRO</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>8/28/71</u></p>	<p>9. AGE (In years last birthday) <u>18</u></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND - JHH</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>
<p>13. FATHER'S NAME <u>James R. Smith</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>Clara Hicks</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p>	
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>POST OP TRACHEO-ESOPHAGEAL FISTULA - BIRTH</u></p> </div> <div style="width: 5%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS.</u></p> </div> </div>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>3</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>AUGUST 28 1971</u> to <u>SEPTEMBER 14 1971</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>SEPTEMBER 14 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Basil John Zitelli MD</u></p>				<p>23B. DATE SIGNED <u>SEPTEMBER 14 1971</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>BASIL JOHN ZITELLI MD</u></p>				<p>23D. ADDRESS <u>601 N. BROADWAY BALTIMORE MD 21205</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u></p>		<p>24B. DATE <u>9/14/71</u></p>		<p>24C. NAME of CEMETERY or CREMATORY <u>Johns Hopkins Hospital</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>Balto., MD.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u></p>			
<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u></p>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8813	
CERTIFICATE OF DEATH					
BIRTH NO. S-325 71-16374 8813		1. NAME OF DECEASED (Type or Print) Baby Boy St. Johns			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 9-18-71 7:30 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1543 E. 29th Street			
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-71	9. AGE Un years last birthday Newborn	If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min. 6 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland-JHH	
12. FATHER'S NAME Donald Brooks		14. MOTHER'S MAIDEN NAME Audrey St. John			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RC Baker, M.D. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 1/2 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-18 (1:30 AM) 19 71 to (7:30 AM) 9-18 19 71 that (I) (we) last saw the deceased alive on 9-18 (7:30 AM) 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond C. Baker, M.D.		23B. DATE SIGNED 9-18-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Raymond C. Baker, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 9/19/71	24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital		24D. LOCATION (City, town, or county) (State) 601 N Broadway, Balto., MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR J. E. Baker, M.D.		25C. FUNERAL DIRECTOR J. E. Baker, M.D. ADDRESS	



B-400⁷¹

8814

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

8814

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERNARD BAILEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 20 1971 3:50 a M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 833			
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 25, 1936		10. AGE (In years last birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Smith		14. STREET AND NUMBER 1219 N. Luzerne Ave.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY None	
15. MOTHER'S MAIDEN NAME Mary Smith			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mary Smith		ADDRESS Same	
19. E-9681X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cranio-cerebral injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 9-2-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? in front of 1131 N. Gay St. 808			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9-2-71 1:15 am		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Struck on head with baseball bat.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-20-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Edward D. Wilson		ADDRESS 1000 Pimlico Ave.	

ACADEMY JUNIO

THE CONTENT

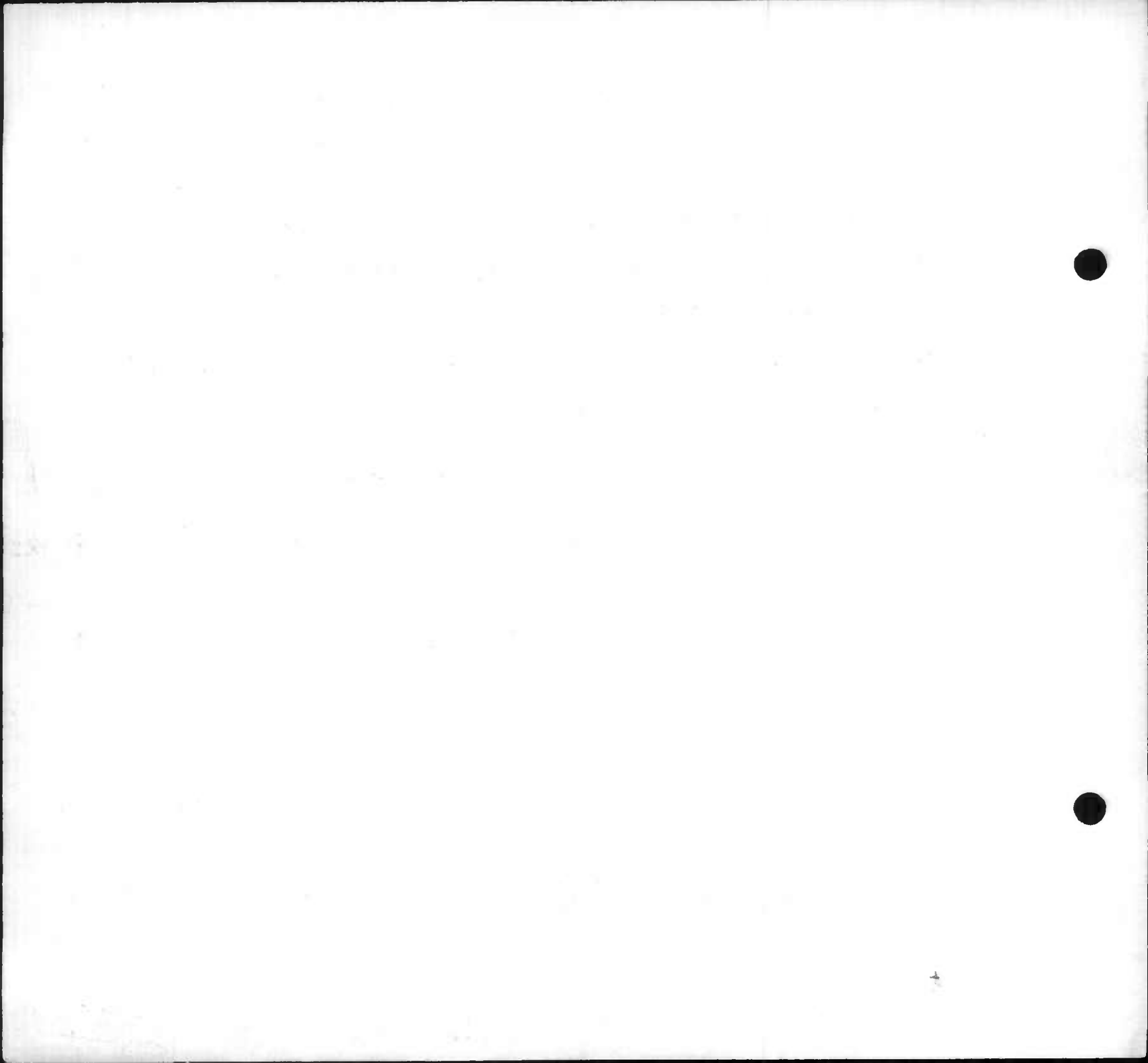
WILL BE AVAILABLE

U.S.A.

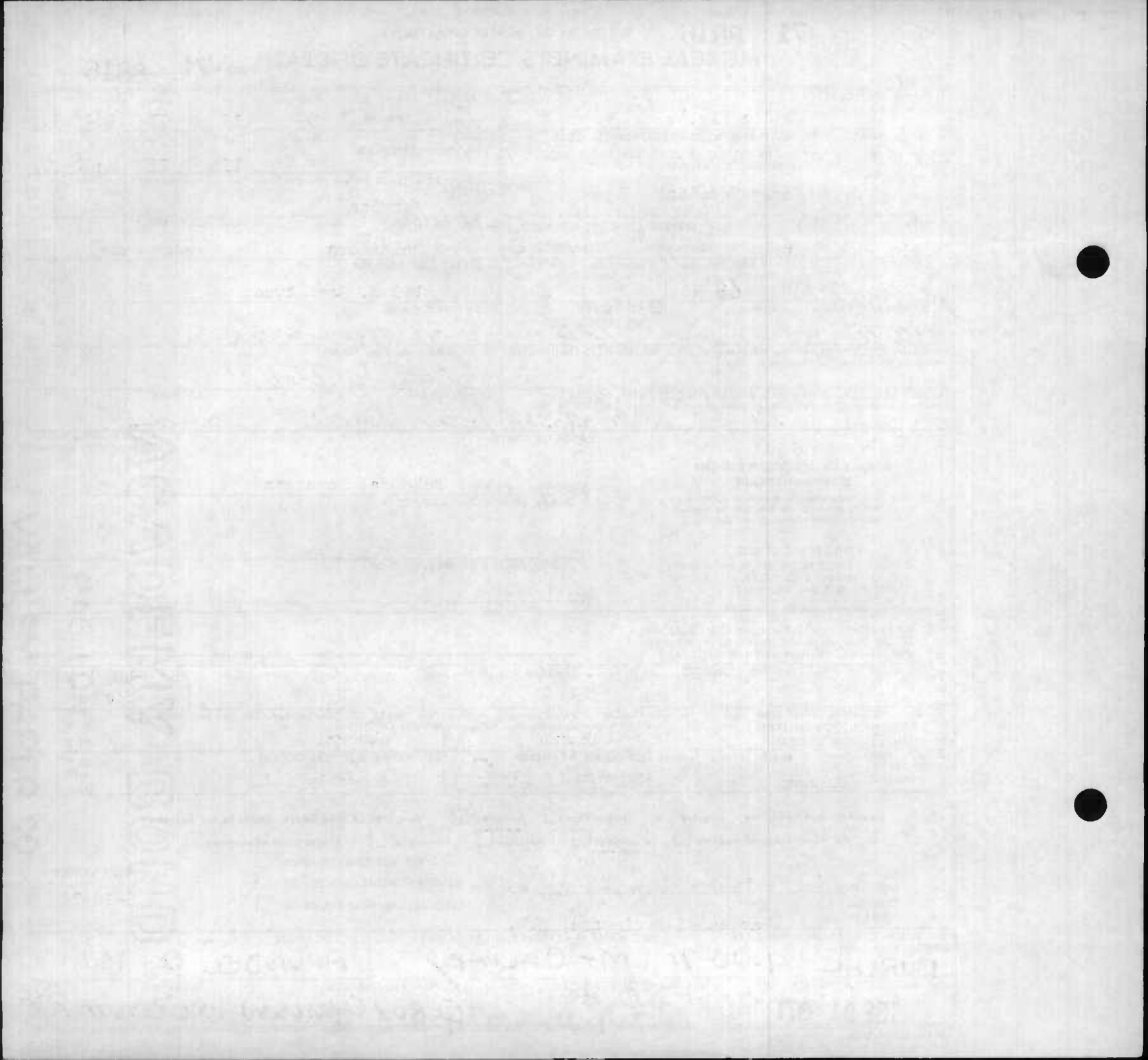
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-350		BALTIMORE CITY HEALTH DEPARTMENT		71 8815		REG. NO. 71 8815	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARTHA REDDIN				2. DATE AND HOUR OF DEATH 17 SEPT 71 6:00 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD GOOD SAMARITAN HOSPITAL				4. USUAL RESIDENCE [Where deceased lived. If institution: residence before admission] A. STATE M.D. B. COUNTY BALTO. CITY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1736 N. GAY ST.			
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 OCT 1903	9. AGE (in years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME FRYE ALLEN				14. MOTHER'S MAIDEN NAME HATTIE BOYKIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 249-88-0070		17. INFORMANT DAUGHTER		ADDRESS	
18. 4-12-81 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UNKNOWN				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) HYPERTENSIVE CARDIOVASCULAR DISEASE 30 YRS DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RENAL FAILURE				1 mo			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 23 AUG-1971 to 17 SEPT 1971 that (I) (we) last saw the deceased alive on 17 SEPT 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE William D. Nellis, M.D.				23B. DATE SIGNED 17 Sept. 71		23C. PHYSICIAN'S NAME (Type) William D. Nellis, M.D.	
23D. ADDRESS Termonville, S.C.				23E. FUNERAL DIRECTOR Barbara Howard J.H.		23F. ADDRESS Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71		24C. NAME OF CEMETERY OR CREMATORY San Bern Co.		24D. LOCATION (City, town, or county) (State) Termonville, S.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Barbara Howard J.H.		25D. ADDRESS Baltimore, Md.	

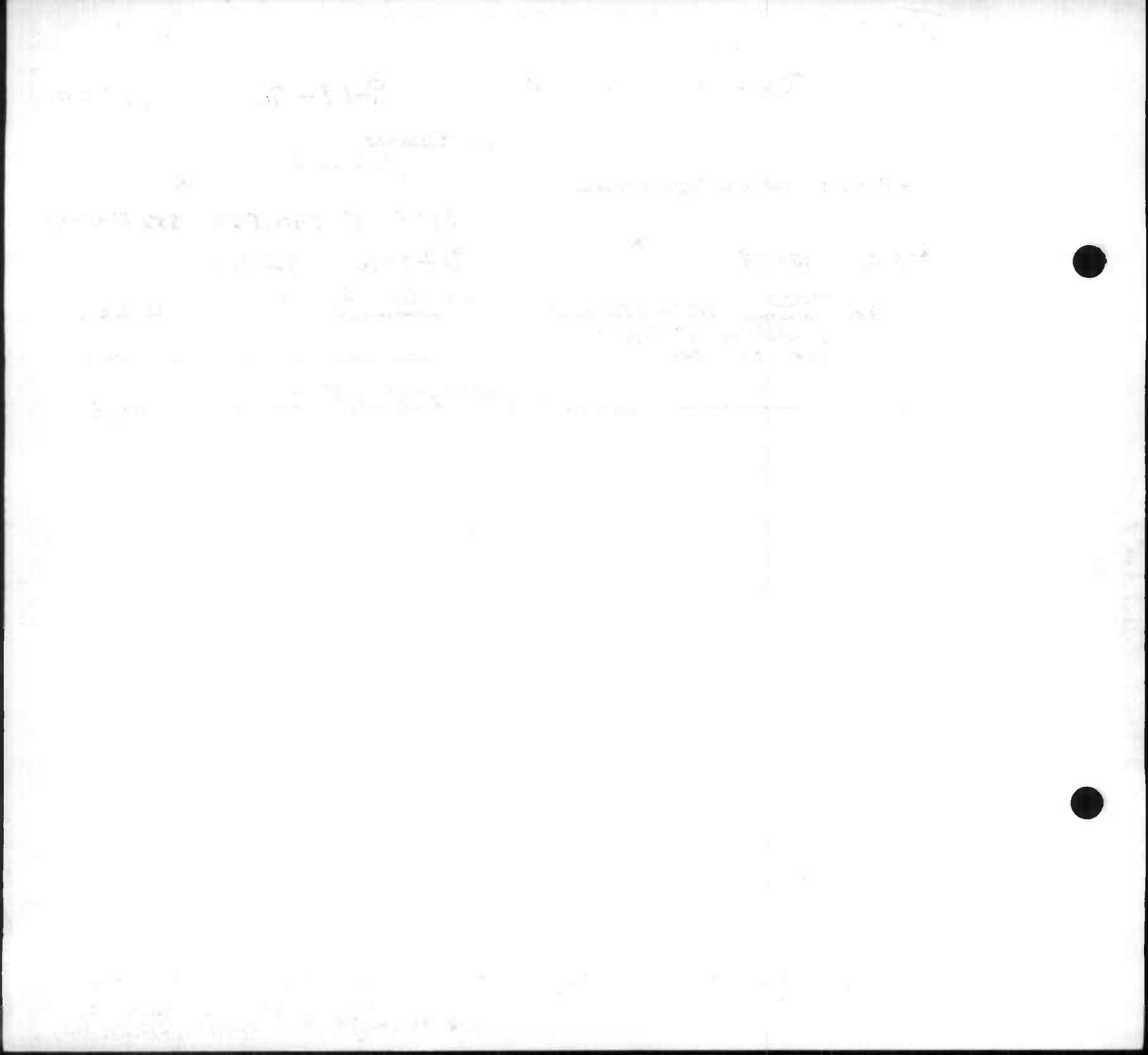


T-240 71 8816		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 8816	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Eddie Tiggie		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 15 71 8:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 15 71 8:40 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan 29-1908		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Tiggie		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Core Northern		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-01-533		18. INFORMANT Hester Tiggie	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural hematoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unknown		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Unknown	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Presumably fell	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9-16-71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-71	
24C. NAME OF CEMETERY or CREMATORY Mt. CALVARY		24D. LOCATION (City, town, or county) (State) ARUNDEL Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Gray & Wilson		ADDRESS 1000 BEANTON AVE	



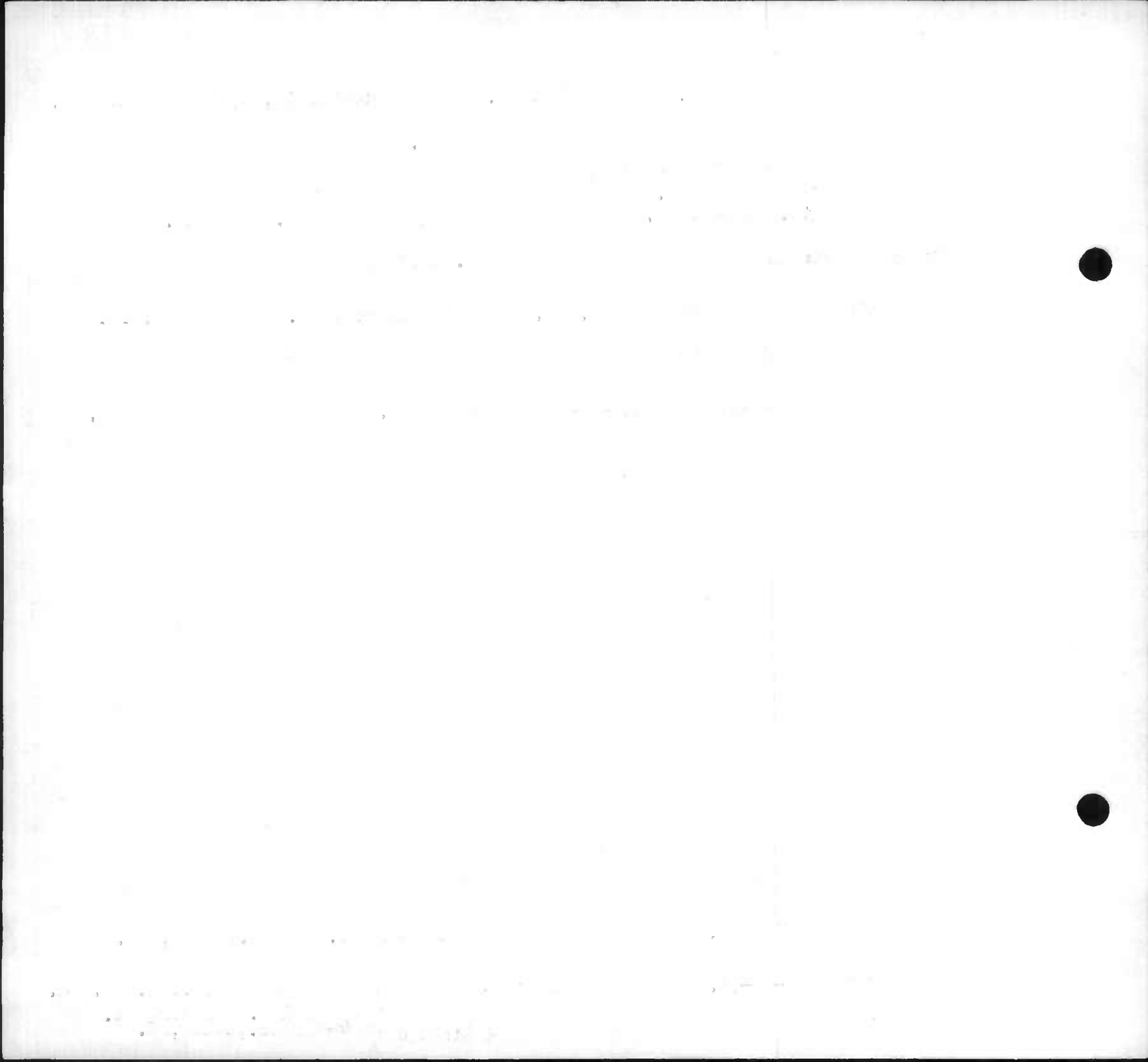
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8817</u>	
BIRTH NO. <u>71 8817</u>		T-260	
1. NAME OF DECEASED (Type or Print) JOHN C. TUCKER		2. DATE AND HOUR OF DEATH 9-17-71 1:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOMER HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 601	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3108 E. FAYETTE ST. #21224.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO.	9. AGE (in years last birthday) 74 Yrs.
11. BIRTHPLACE (State or foreign country) ST MARY'S, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. TUCKER		14. MOTHER'S MAIDEN NAME VIRGINIA DE VAUX	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-01-0385A	17. INFORMANT MARGARET N. TUCKER ADDRESS SAME
18. 4-12-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
19A. DATE OF OPERATION 9-17-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-17-71 to 9-17-71 that (I) (we) last saw the deceased alive on 9-17-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Satpal Singh		23B. DATE SIGNED 9.17.71.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-71.	24C. NAME OF CEMETERY or CREMATORY WOODLAWN CEM.
24D. LOCATION (City, town, or county) (State) DOGWOOD RD. BALTO, CO., MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Charles S. Jalev	
25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-362 71 8818</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8818</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) ERNEST J. STRICKLIN, SR.</p>		<p>2. DATE AND HOUR OF DEATH September 16, 1971 11:15 P. M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>31 Baltimore City Hospital 4940 Eastern Ave. Balto., 21224, Md.</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY 2609</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3416 Fait Ave. # 21224.</p>	
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Mar. 15, 1903</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Western Elec. Co.</p>	<p>9. AGE (In years last birthday) 68</p>
<p>11. BIRTHPLACE (State or foreign country) Baltimore, Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME John Stricklin</p>		<p>14. MOTHER'S MAIDEN NAME Grace Kerr</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 217-03-6930A</p>	<p>17. INFORMANT Theodora E. Stricklin : ADDRESS Same.</p>
<p>18. 4-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Myo cardiac Infarction</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 9/10/71</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) No</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from May 1967 to 9/16 1971 that (I) was last saw the deceased alive on Sept. 9 1971 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did not) view the body after death.</p>			
<p>23A. SIGNATURE Joseph R. Liberto MD</p>		<p>23B. DATE SIGNED 9/18/71</p>	<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO</p>		<p>23D. ADDRESS 3500 Bank St., Balto., 21224, Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 9-20-71.</p>	<p>24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971</p>	<p>25B. NAME OF REGISTRAR Robert E. Taylor, MD</p>	<p>25C. FUNERAL DIRECTOR Charles S. J. J. J.</p>	<p>ADDRESS 901 S. Conkling St. Balto., 21224, Md.</p>



R-000 71

8819

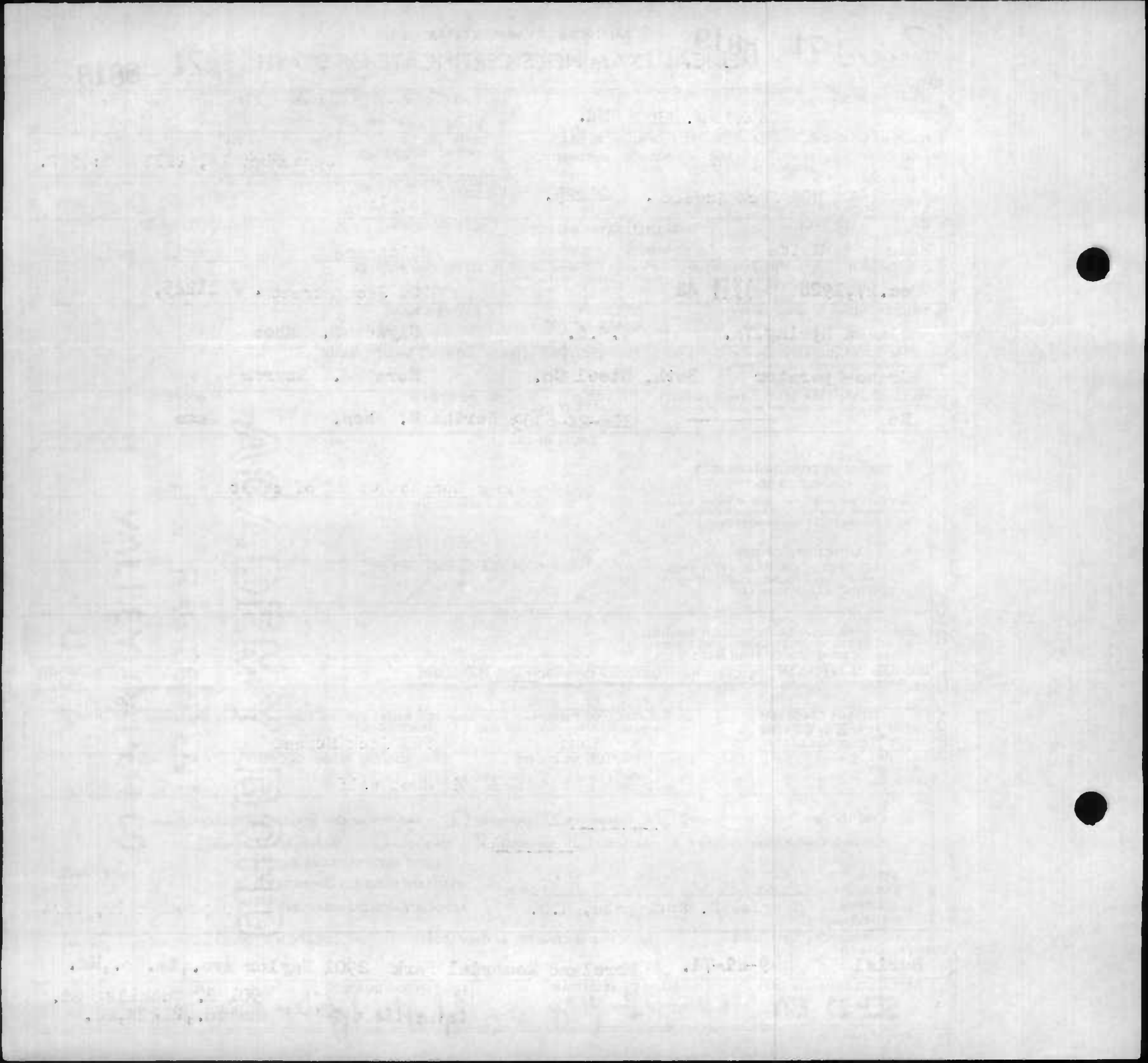
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8819

BIRTH NO.

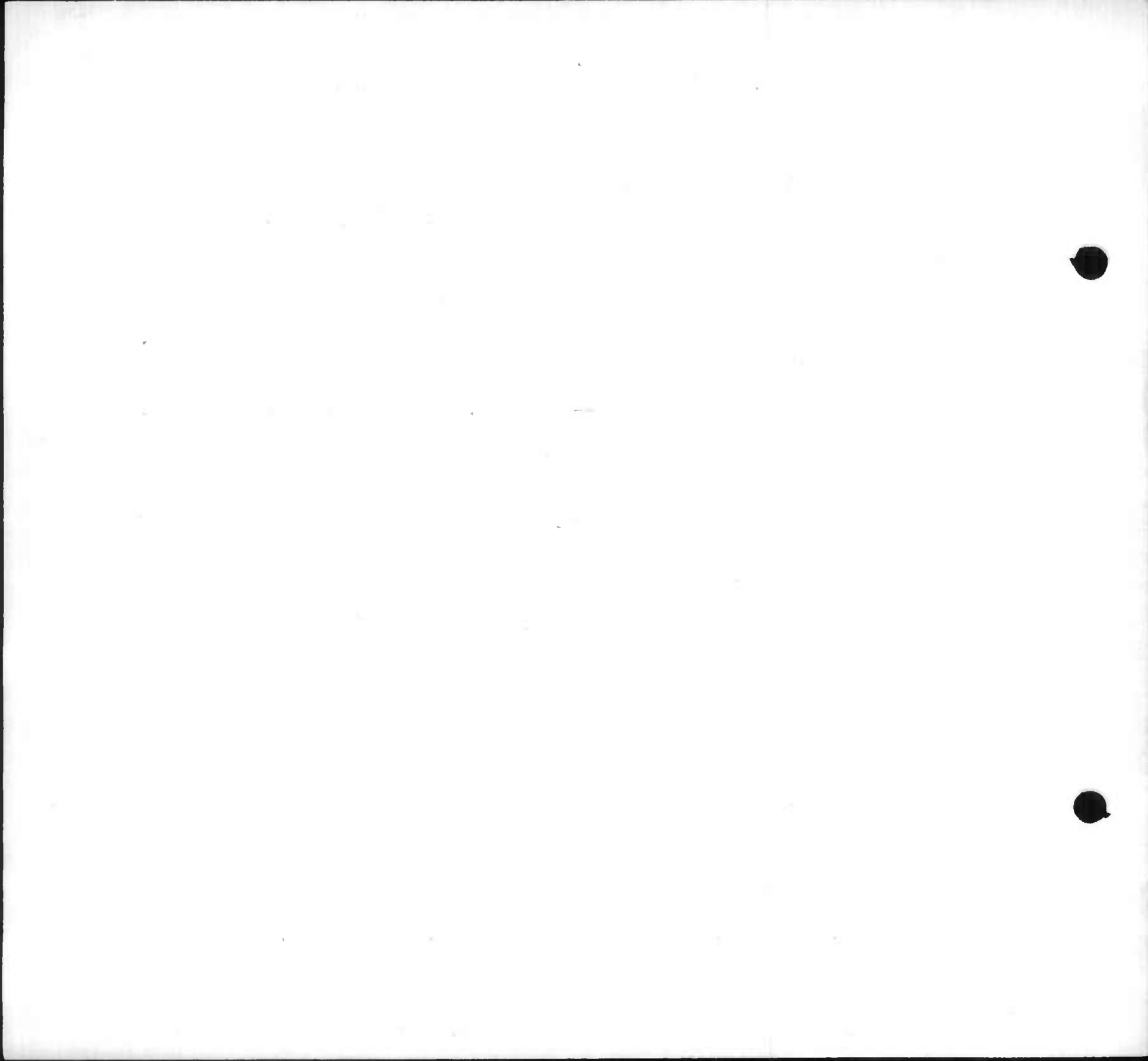
1. NAME OF DECEASED (Type or Print) GEORGE W. RHEA SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 908 Jack Street. # 21225.		3. DATE PRONOUNCED DEAD Month Day Year Hour September 18, 1971 2:45 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 27, 1928		10. AGE (In years lost birthday) 42	
11. BIRTHPLACE (State or foreign country) Glades Spring, Va.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane-Operator		14B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-24-6303	
18. INFORMANT Bertha M. Rhea.		ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 908 Jack Street		22F. HOW DID INJURY OCCUR? Shot self	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) ? ? ? ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		DATE SIGNED September 19, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-71.	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) 2901 Taylor Ave., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles S. Springate		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

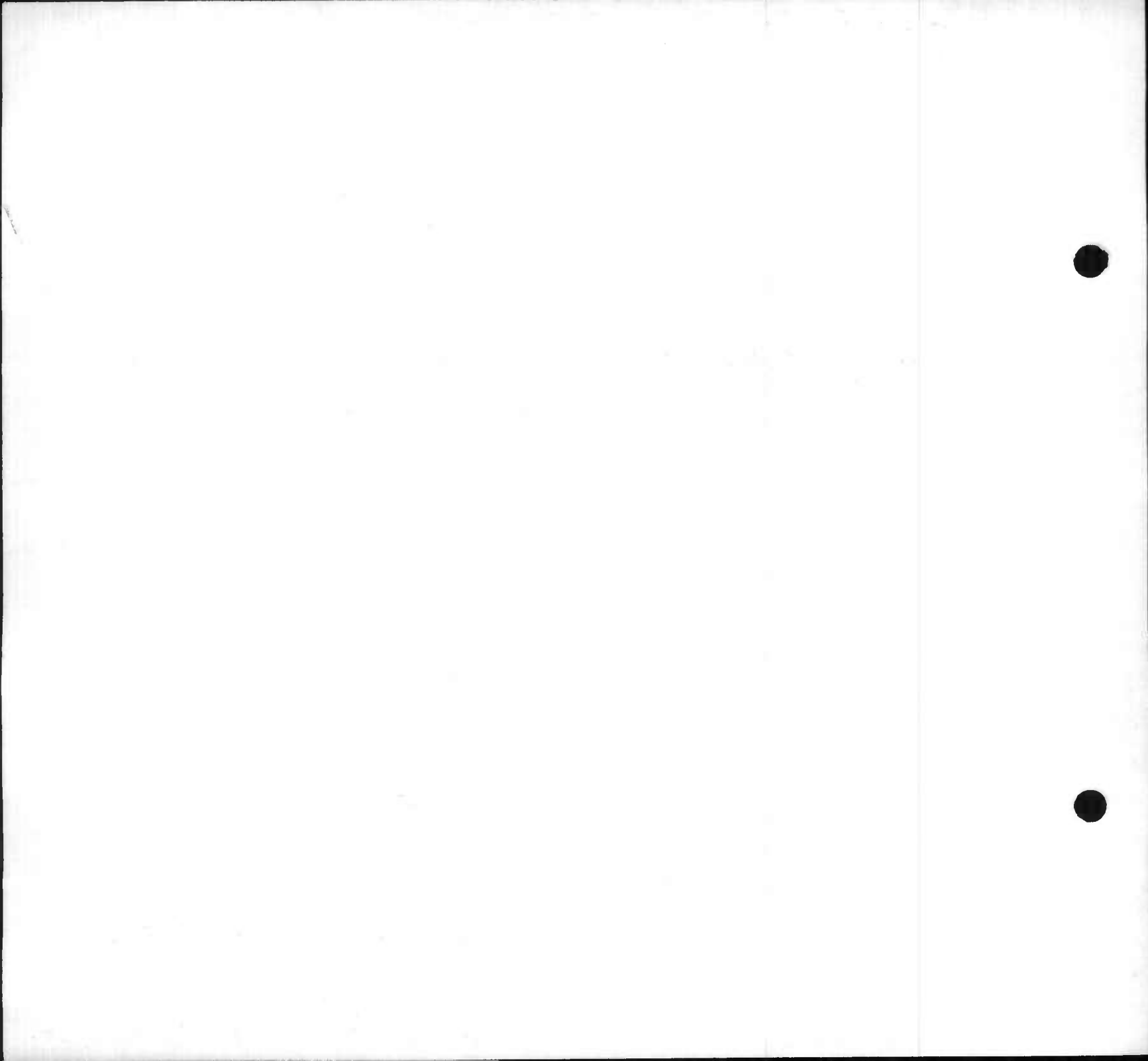
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8820</u>	
<div style="display: flex; justify-content: space-between;"> M-460 71 8820 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hilda L. Mueller</u>			
2. DATE AND HOUR OF DEATH <u>9/20/71</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2511 Hollins Street</u>		A. STATE <u>Md</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2511 Hollins Street</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/1894</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>William Bode</u>		14. MOTHER'S MAIDEN NAME <u>Caroline</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Paul Mueller, 2511 Hollins St.</u>	
18. <u>433717-2507</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>Anterior clemis, generalized</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) High blood pressure</u> <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 mos.</u> <u>15 years</u> <u>17 yrs. 8 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1954</u> to <u>Sept. 20, 1971</u> that (I) was last saw the deceased alive on <u>Sept. 14, 1971</u> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gilbert E. Rudman, M.D.</u>		23B. DATE SIGNED <u>9/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Gilbert E. Rudman</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Vitzke, 1630 Edmondson Ave., 21228</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					



FUNERAL DIRECTOR: IMPORTANT

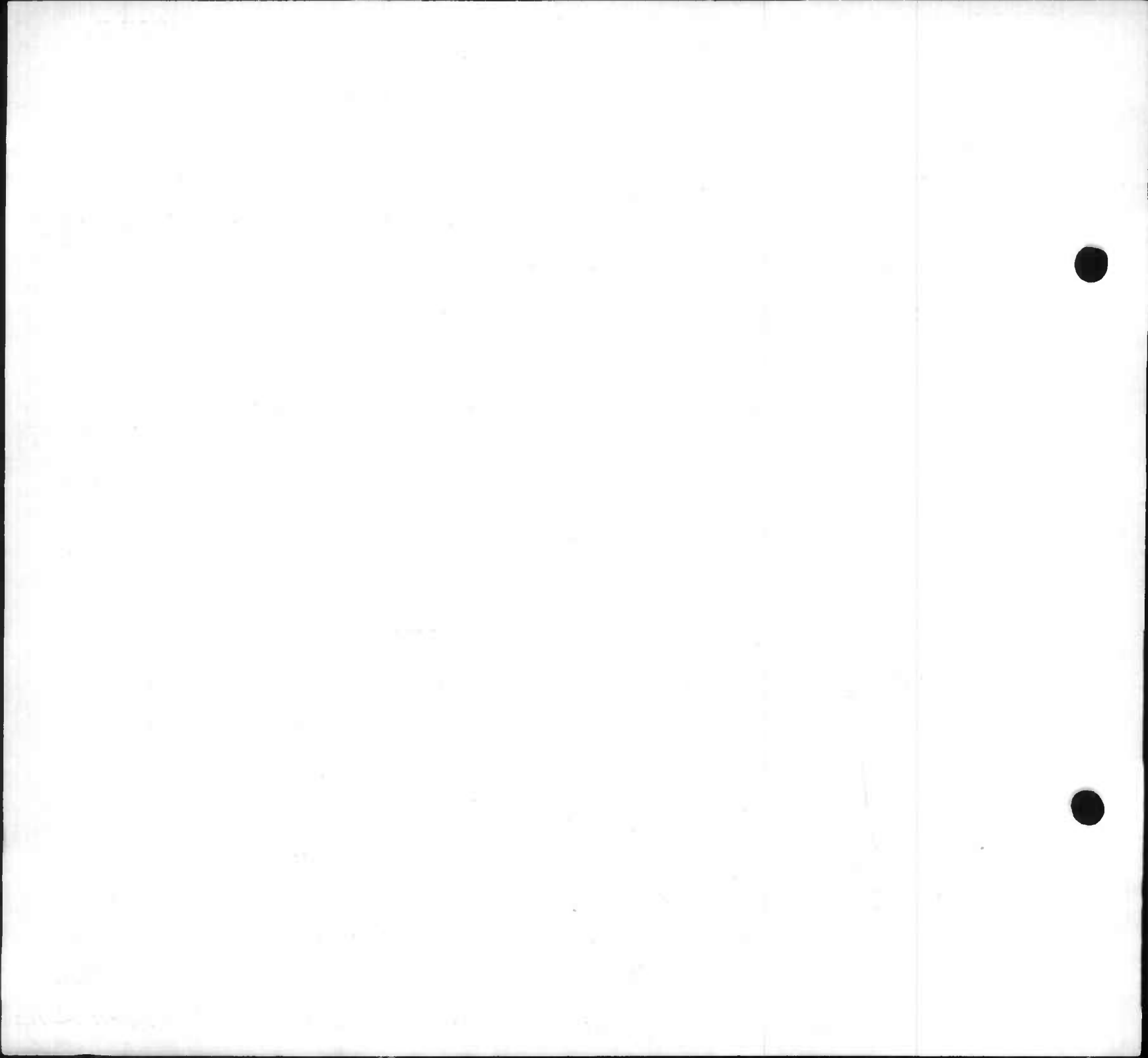
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8821	
BIRTH NO. X-134 71 8821					
1. NAME OF DECEASED (Type or Print) LOUIS KUPIDROWSKI		2. DATE AND HOUR OF DEATH 9. 17. 71 12.45A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & 35 HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 203 C. CITY OR TOWN BALTIMORE CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 623 S. Durham St.			
5. SEX MALE	6. RACE B W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1. 3. 1915	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY I.L.A. STEAMSHIP		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME WADYSZAW KUPIDROWSKI		14. MOTHER'S MAIDEN NAME MICHALINA FILIPAK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-0911		17. INFORMANT ADDRESS Hospital chart.	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: Unknown			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9. 17. 71 to 9. 17. 71 that (I) (we) last saw the deceased alive on 9. 17. 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sargal R. J.		23B. DATE SIGNED 9. 17. 71.			
23C. PHYSICIAN'S NAME (Type) DEGREE		23D. ADDRESS Church Home Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/71		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cem.	
24D. LOCATION Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Reg. E. J. J.		25C. FUNERAL DIRECTOR ADDRESS 263 S. Conkling St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8822</u>
BIRTH NO. <u>W-414 71 8822</u>				
1. NAME OF DECEASED (Type or Print) <u>RONALD WOOLFOLK</u>		2. DATE AND HOUR OF DEATH <u>9/16/71 1050 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>808</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1002 N. WASHINGTON ST 21205</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/40</u>	9. AGE (In years last birthday) <u>31 years</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NOT KNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>CLYDE</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>PATIENT'S CHART</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> (A) IMMEDIATE CAUSE <u>CESSATION OF Bp, Pulse, + Respiration</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MASSIVE + REPEATED UGI Bleed</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>20 ESOPH. VARICES 2° ETOH.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>9/8/71; 9/9/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding Esoph. Varices</u>		20A. AUTOPSY? (Yes or No) <u>—</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Not Applicable</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Longstanding Disease</u>
22. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> 19 <u>71</u> to <u>9/16</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>9/16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Richard W. Fidele</u> M.D.		23B. DATE SIGNED <u>9/16/71</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD W. FIDELER</u>
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/21/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mrs E MARCH</u>		
ADDRESS <u>928 E. NORTH AVE</u>				



FUNERAL DIRECTOR: IMPORTANT

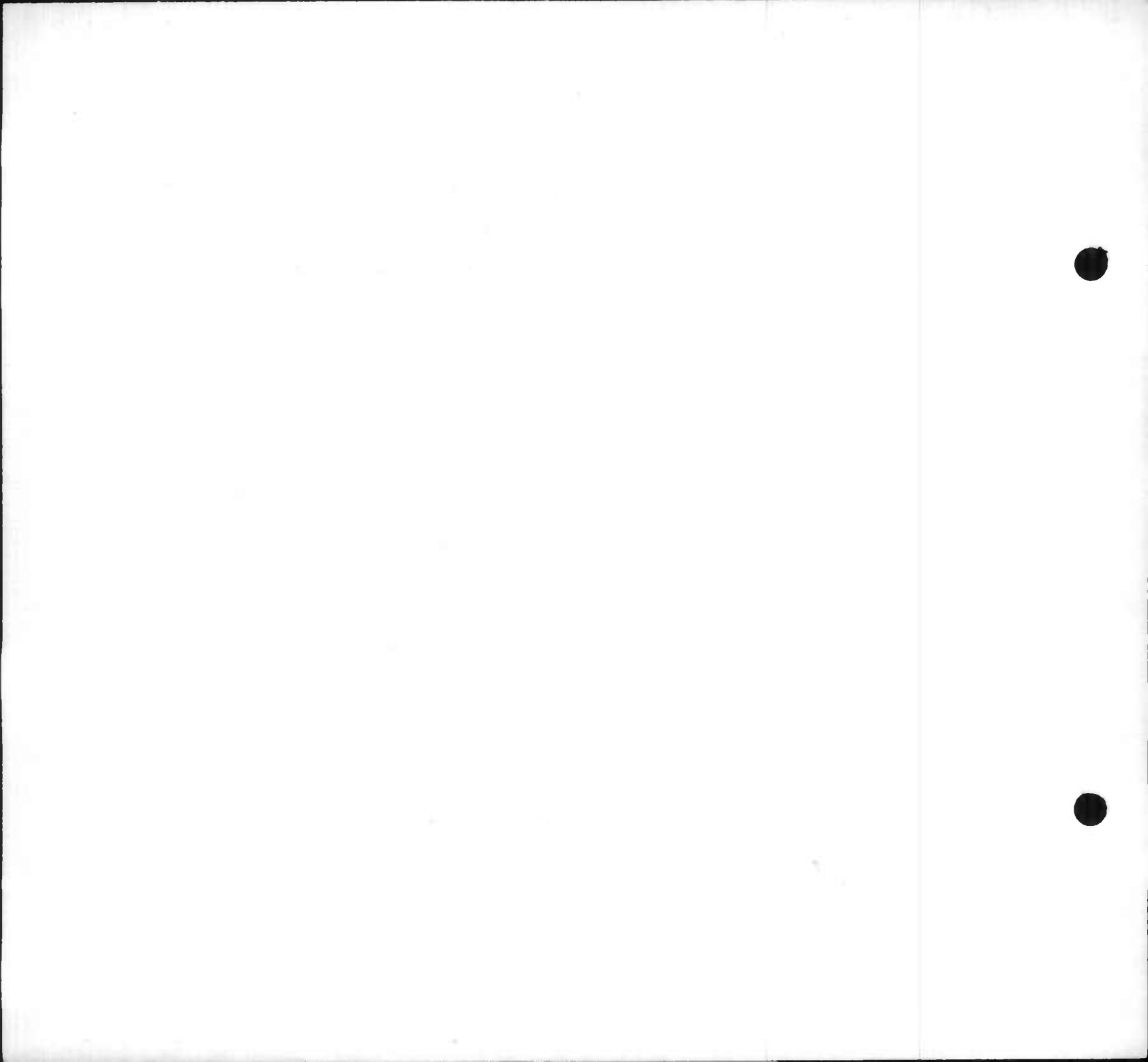
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 71 8823		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 8823 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLAUDIE BARNES		2. DATE AND HOUR OF DEATH SEPTEMBER 14 1971 6:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 22 01		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Ashburton Nursing Home 3525 N. Hutton Rd Baltimore, Md 21216		E. STREET AND NUMBER 311 Sharp St			
5. SEX M	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-17	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CLAUDIE BARNES		14. MOTHER'S MAIDEN NAME unk.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO.		17. INFORMANT LAVENIA BARNES 1008 S. PAPA ST.	
18. 147 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of nasopharynx ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 8 1971 to Sept. 14 1971 that (I) (we) last saw the deceased alive on Sept. 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Abraham B. Hurwitz MD		23B. DATE SIGNED Sept. 16, 1971		23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ MD	
23D. ADDRESS 7501 Liberty Rd. Baltimore Md.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/71	
24C. NAME OF CEMETERY OR CREMATORY MT. CALVERY		24D. LOCATION (City, town, or county) (State) BROOKLYN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

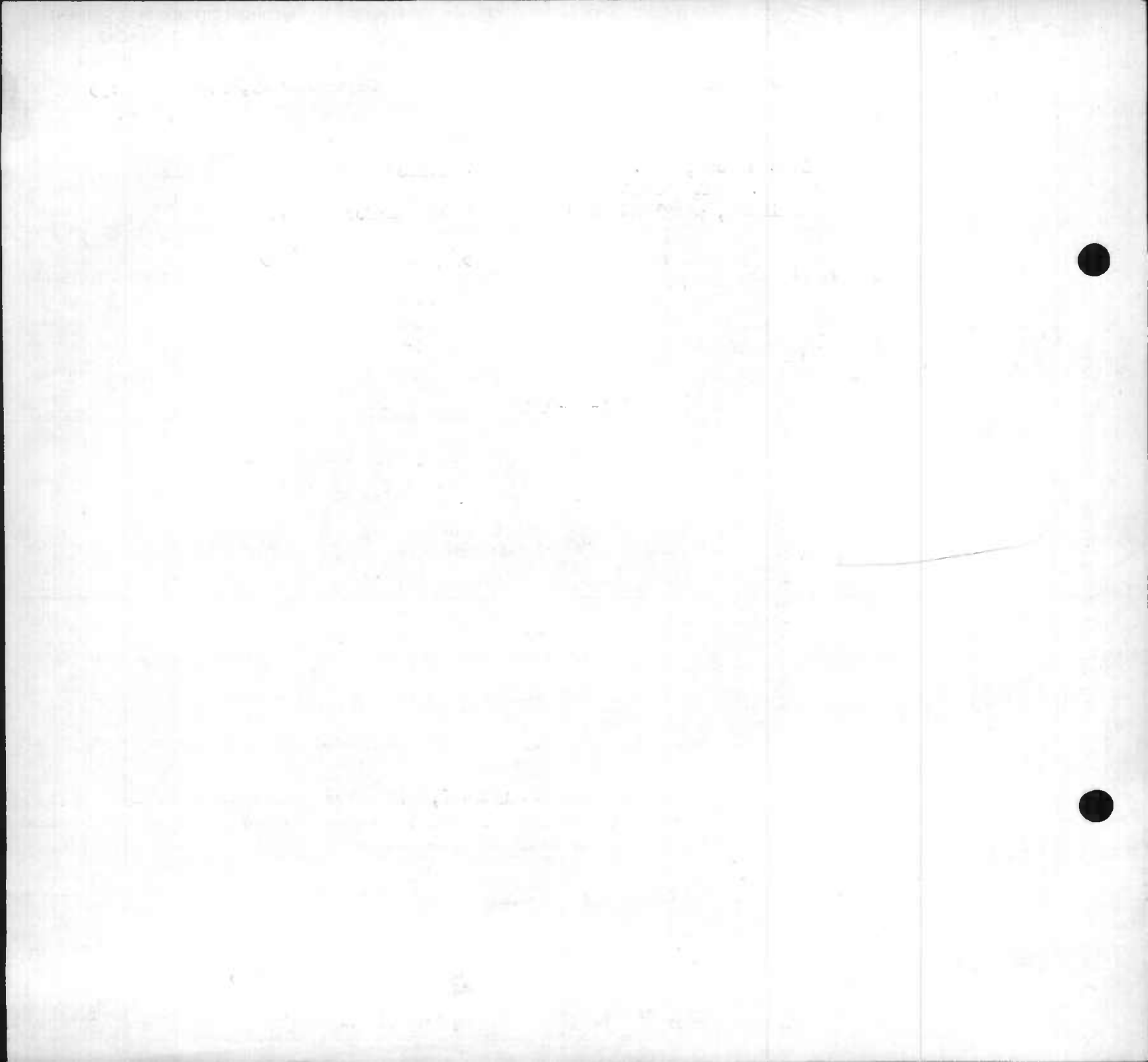
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8824</u>	
BIRTH NO. <u>W-452 71 8824</u>					
1. NAME OF DECEASED (Type or Print) <u>CHARLIE HENRY Williams</u>		2. DATE AND HOUR OF DEATH <u>9/20/71</u> <u>14.05</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY of MARYLAND Hospital</u>		4. USUAL RESIDENCE (Where Deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1702</u>			
		5. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1305 Druid Hill Ave.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-16</u>	9. AGE (in years last birthday) <u>55</u>	11. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Vol.</u>	
13. FATHER'S NAME <u>WALLACE WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE BROWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>5-17-XI</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Pseudomonas bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>GRANULOMA left upper lobe</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8/25/71 - 9/20/71</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Renal FAILURE</u>					
19A. DATE OF OPERATION <u>8/23/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GRANULOMA left UPPER LOBE</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 16</u> 19 <u>71</u> to <u>SEPTEMBER 20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>SEPTEMBER 20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. L. Loman, M.D.</u>		23B. DATE SIGNED <u>9/20/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN M. FLORIAN, M.D.</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-23-71</u>		24B. DATE <u>9-23-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Tricolen Memorial Portsmouth Va</u>	
24D. LOCATION (City, town, or county) (State) <u>Portsmouth Va</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Adelbert Funeral Home</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8825	
<div style="display: flex; justify-content: space-between;"> J 250 1 71 8825 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Tom JACKSON		September 19, 1971 9:35 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			A. STATE Md B. COUNTY 1203 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2600 Guilford Avenue		
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/06	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Virginia	
13. FATHER'S NAME Archie Jackson			14. MOTHER'S MAIDEN NAME Nannie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 231-24-0909		17. INFORMANT ADDRESS Mrs Betty Dunnigan, 3200 St Ambrose	
18. 412.4 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure Congestive Heart Failure Coronary Vascular Accident (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (C) Pneumonia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			terminal Pneumonia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 7, 1970 19 to September 19 1971, that (I) (we) last saw the deceased alive on 9/19 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William D Applefeld				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William D Applefeld MD				23D. ADDRESS 6615 Reisterstown Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/23/71		24C. NAME OF CEMETERY OR CREMATORY MT Auburn C'metry	
				24D. LOCATION (City, town, or county) (State) Baltimore, MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert S. Taylor, Jr.		25C. FUNERAL DIRECTOR Adolphus Halstead	
				ADDRESS 1206 W North Ave	

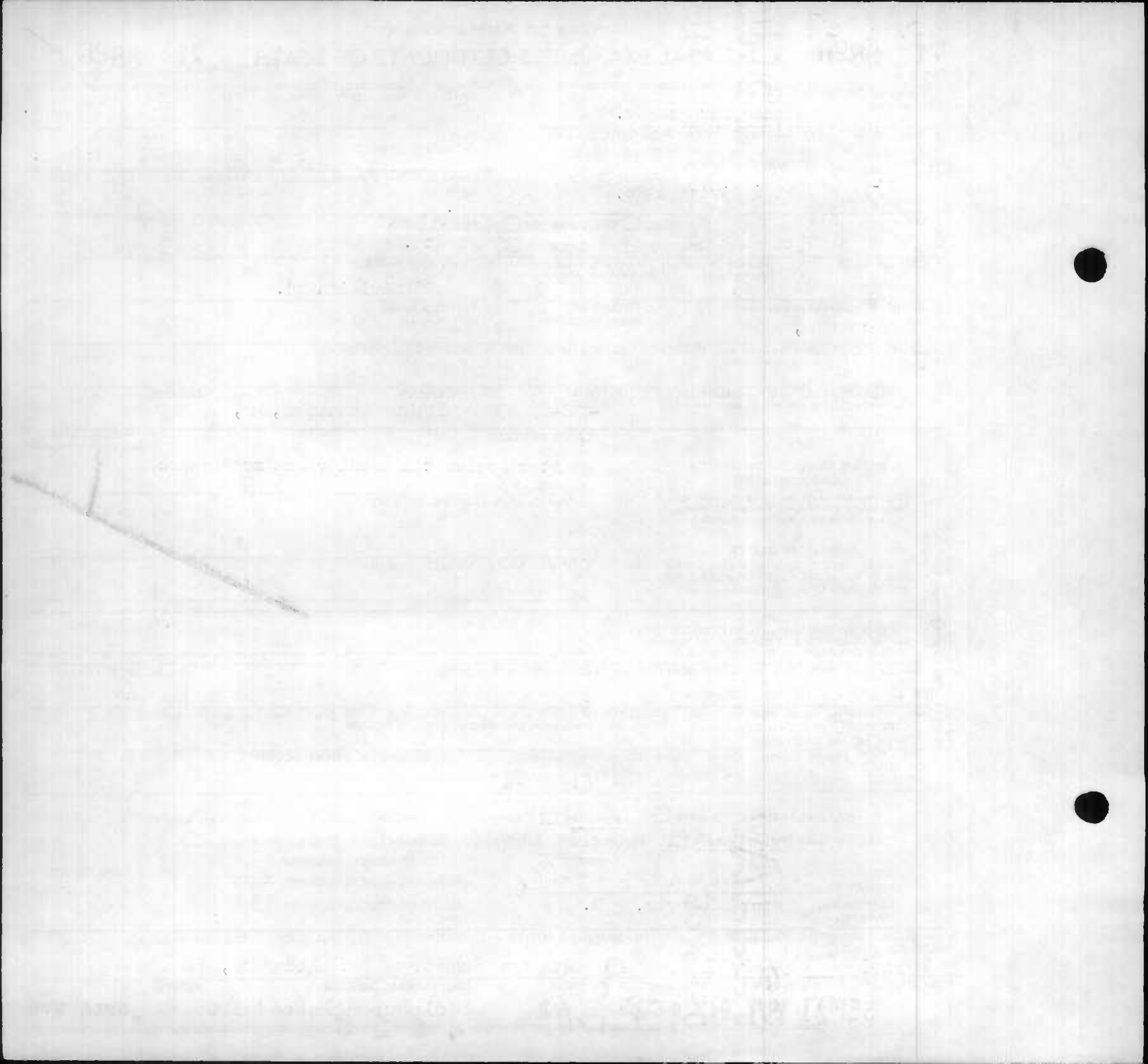


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8826

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alonzo Burnham Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 16 71 Hour 12:50 a. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1206 Division St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 16 71 12:50 a. m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1702	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 84	
11. BIRTHPLACE (State or foreign country) Savannah, Ga		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alonza Jackson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Jennie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 218-10-2880		18. INFORMANT MR Alonza Burnham, Jr, Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> xx ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 9/17/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/71	
24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W north Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MABEL LEIGHTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 18, 1971		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 18, 1971		Hour 7:40 P.M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1403				
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 7/20/27		10. AGE (In years last birthday) 43	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Felonious Reiley		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME Edith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
17. SOCIAL SECURITY NO. 21-5522-579		18. INFORMANT James Leighton		
19. 4309 I		ADDRESS ,3230 Mohawk Ave		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF:				
(B) Ruptured saccular aneurysm DUE TO, OR AS A CONSEQUENCE OF:				
(C)				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/25/71		24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, M.				
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Jarboe, R.D.		25C. FUNERAL DIRECTOR Adolphus Halstead
				ADDRESS 1206 W north Ave

U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

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95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 8828

BIRTH NO. 71 8828

BEAN

1. NAME OF DECEASED

(Type or Print)

Willie Mae Bean

2. DATE AND HOUR OF DEATH

Sept 20, 1971 5:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Key Circle Hospice 1214 Eubw Plue B, H, Md 21217

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Md B. COUNTY B. H. C. H.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2023 Penns Ave

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

5-12-08

9. AGE (In years last birthday)

63

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Albany, Montgomery

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Garfield McDade

14. MOTHER'S MAIDEN NAME

Sarah McDade

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Samuel Bean Jr. 2023-Penns. Ave

ADDRESS

18. 4369 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardio pulmonary arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

LT. CVA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Syrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 17 19 71 to Sept. 20 19 71 that (I) (we) last saw the deceased alive on Sept 20 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

H. E. Bondy

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

9-20-71

23C. PHYSICIAN'S NAME (Type)

H. E. Bondy

DEGREE

23D. ADDRESS

Key Circle Hospice

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-22-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 21 1971

25B. NAME OF REGISTRAR

Robert E. Talley, R.D.

25C. FUNERAL DIRECTOR

Morton & Dyett F. H. 1701 Laurens St.

ADDRESS

X

1944

X

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71, 8829</u>	
<p>71 8829</p> <p>BIRTH NO. <u>254</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>THOMAS SHAW</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9/20/71</u> <u>7 pm</u> M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>Maryland General Hosp.</u> <u>827, Linden Ave.</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>1513</u></p> <p>E. STREET AND NUMBER <u>2406 Loyola Northway</u></p>		
<p>5. SEX <u>M</u></p>		<p>6. RACE <u>N</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <u>11/17/45</u></p>		<p>9. AGE (In years last birthday) <u>25</u></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	
<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Md. Dry Dock</u></p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Baltimore Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p>	
<p>13. FATHER'S NAME</p> <p><u>Thomas Shaw</u></p>			<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Hannie Shaw</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p> <p><u>Hannie Shaw - 2406 Loyola Northway</u></p>	
<p>18. <u>163.1 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>Ca of the mediastinum</u> <u>metastases to L + lung</u> <u>and pericardium.</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>9/20/71</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Refused</u></p>		<p>20A. AUTOPSY? (Yes or No) <u>Refused</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No injury</u></p>	
<p>21D. TIME OF INJURY (Approx.) _____</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u>4:58 pm</u></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>71</u> to <u>9/20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>[Signature]</u></p>				<p>23B. DATE SIGNED <u>9-20-71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>C. GAKUBA</u></p>				<p>23D. ADDRESS <u>Maryland General 827, Linden Ave.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>9-25-71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem Pk.</u></p>	
<p>24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u></p>		<p>24E. STATE (State) <u>St.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u></p>	
<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor</u></p>		<p>25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u></p>		<p>25D. ADDRESS <u>1701 - Laurens</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 8830

BIRTH NO. 71 8830

1. NAME OF DECEASED (Type or Print) <u>Rosalia Williams (Rosa)</u>		2. DATE AND HOUR OF DEATH <u>9-20-71</u> <u>12:30</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>46</u> <u>Auburn Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46</u> <u>Auburn Hospital</u>		C. CITY OR TOWN <u>Bethesda</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-28</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) <u>43</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Martin Co N.C.</u>	
13. FATHER'S NAME <u>Wilbur Manning</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Manning</u>		17. INFORMANT <u>James Williams 2828-W North Ave</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	

18. <u>1506 X I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of esophagus metastasis</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Carcinoma of esophagus metastasis</u> A Months DUE TO, OR AS A CONSEQUENCE OF:	
		(C) <u>Carcinoma of esophagus metastasis</u> A months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			

19A. DATE OF OPERATION <u>9-20-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			

22. I certify that 46 (this hospital) attended the deceased from 8-29- 1971 to 9-20- 1971 that (I) yes last saw the deceased alive on 9-20- 1971 and that (in my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.

23A. SIGNATURE <u>J. Manning</u>		23B. DATE SIGNED <u>9-20-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JASON SAMUEL M.D.</u>		23D. ADDRESS <u>1730 Ashburton Street, Baltimore, MD 21216</u>	

24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-24-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>NH Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Farber, M.D.</u>		ADDRESS <u>1701 E. H. Lawrence St</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8831

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1704 W. Lafayette Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 20 1971 2:30 a.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1402	
9. DATE OF BIRTH April 15, 1938		10. AGE (In years last birthday) 33	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Robert W. Johnson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Laura Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Viola Johnson 2528 Garrett Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) basement		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1704 W. Lafayette Ave. 1603	
22D. TIME OF INJURY (APPROX.) 9-20-71 2 a m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot self.		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-20-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

ACADEMY RECORD

HAS CONTENT

VALLEY APPEAL CO

15-21

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

71 8832

REG. NO. 71 8832

1. NAME OF DECEASED (Type or Print) STEWART SCRIBNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1704 W. Lafayette Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 20 1971 2:30 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1-8-53		10. AGE (In years last birthday) 18	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley V. Scribner		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1901	
15. MOTHER'S MAIDEN NAME Theresa Duppins		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Theresa Scribner	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9-20-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) basement		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1704 W. Lafayette Ave.	
22D. TIME OF INJURY (APPROX.) 9-20-71 2 a m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot by assailant.		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-20-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

and

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W. 320

BALTIMORE CITY HEALTH DEPARTMENT

71-8833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 8833

1. NAME OF DECEASED (Type or Print) Kia S. Woods		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 1971 10:30 a M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-31-1971		10. AGE (In years last birthday) 5	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT James Lee Woods		ADDRESS 2902 Clifton Avenue	
19. CAUSE OF DEATH Sudden Death in Infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-1971	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

ACADEMY PROGRAM

FOR CONDUCT

THE ACADEMY

OF THE

UNITED STATES

NAVY

AND

COAST GUARD

OFFICE

OF THE

CHIEF OF NAVAL OPERATIONS

WASHINGTON, D.C.

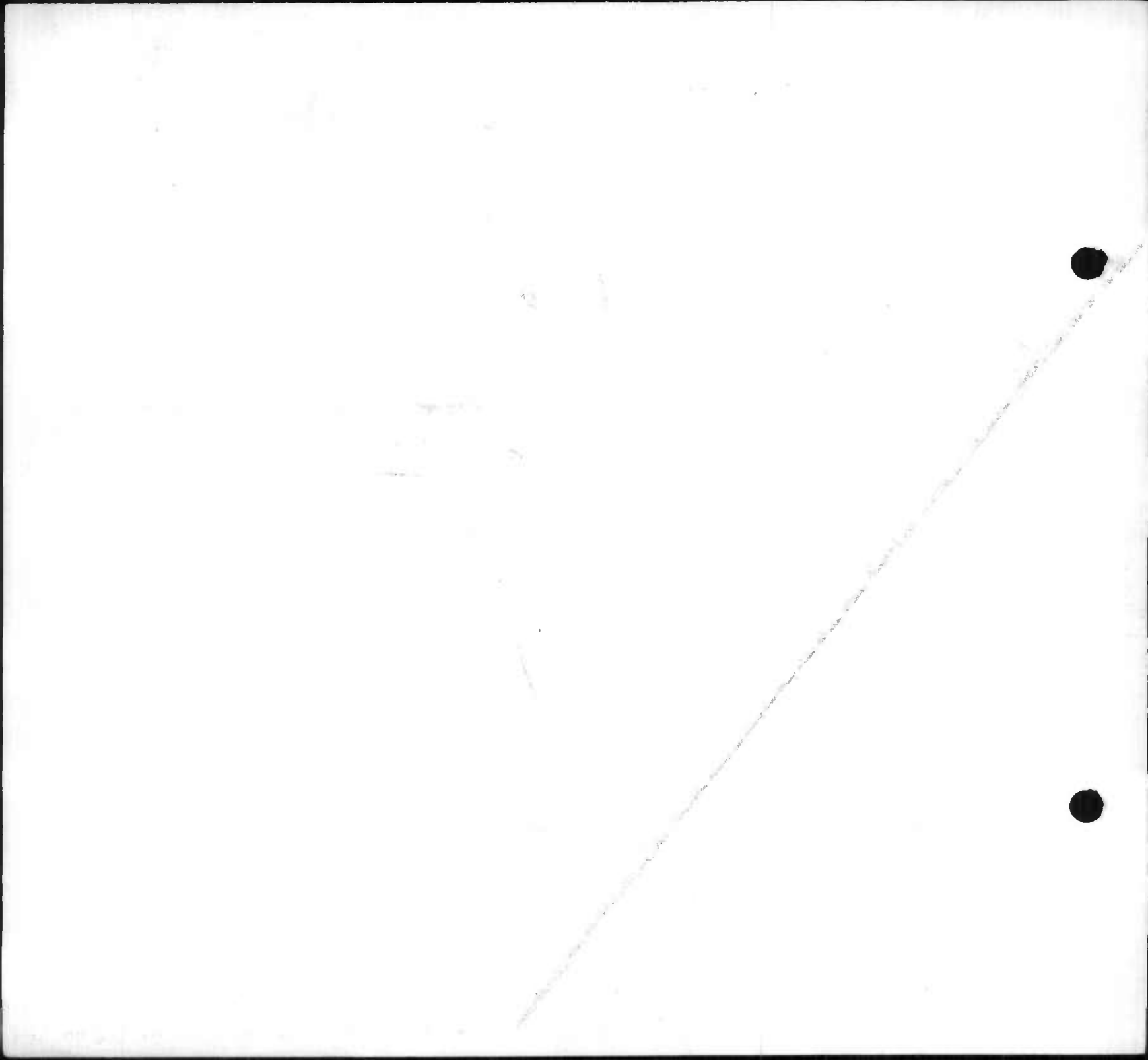
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8834	
BIRTH NO. 71 8834				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Samuel E. Harmon			2. DATE AND HOUR OF DEATH September 17, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3607 OAKMOUNT AVE.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2798 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3607 OAKMOUNT AVENUE		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/24	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY Curtis Bay	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Harmon			14. MOTHER'S MAIDEN NAME Hartense Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> World War II		16. SOCIAL SECURITY NO. 218-18-3669	17. INFORMANT Gertrude Harmon 3607 Oakmont Avenue		
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ASDHO to previous myocardial infarction + cardiac arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos - min					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/10 19 71 to 9/11 19 71 that (1) (we) last saw the deceased alive on 9/11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eliza Saunders			23B. DATE SIGNED 9-20-71		
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS M.D.			23D. ADDRESS 2300 GARRISON BOULEVARD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-71		24C. NAME of CEMETERY or CREMATORY St. Luke's Cemetery	
24D. LOCATION (City, town, or county) (State) Reisterstown Maryland		25A. DATE RECEIVED BY HEALTH DEPT. SEP 21 1971			
25B. NAME OF REGISTRAR Robert E. Nalley, Jr.		25C. FUNERAL DIRECTOR NETTER FUNERAL HOME 3035 W. North Ave.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

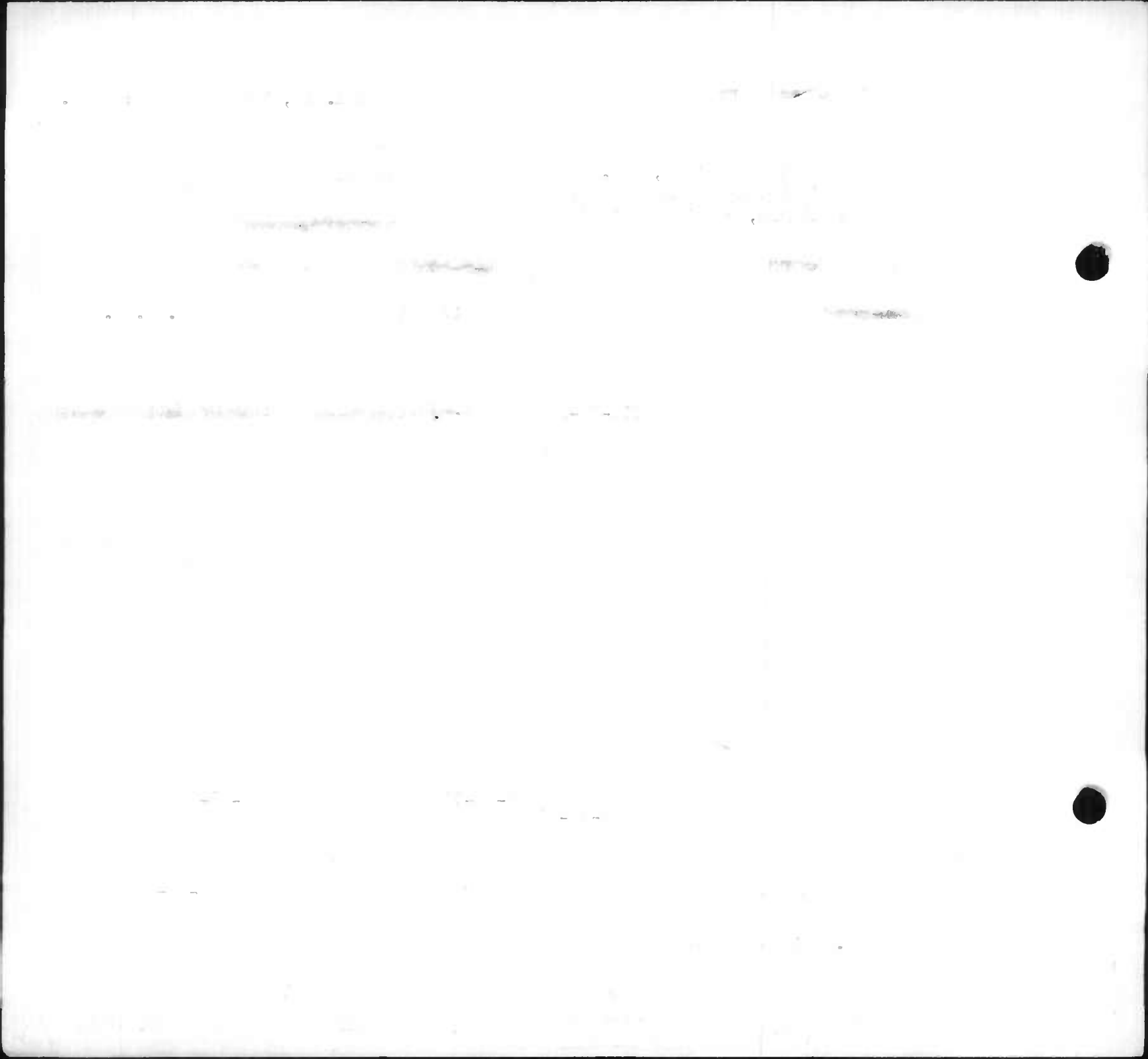
M-2501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8835

BIRTH NO. 71 8835

1. NAME OF DECEASED (Type or Print) Prince Albert Mason		2. DATE AND HOUR OF DEATH Sept. 18, 1971 10:35 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1702	
5. SEX Male		6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-1889	
9. AGE (In years last birthday) 82		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Abex Corporation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Mason		14. MOTHER'S MAIDEN NAME Mary Eliza Hines	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9588	
17. INFORMANT Mrs. Ethel Mason		ADDRESS 1102 Druid Hill Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HA SCVD & congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable occult malignancy of Cushing's Syndrome	
(B) DUE TO, OR AS A CONSEQUENCE OF: 18 mos		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-15-71 to 9-18-71 and that (I) (we) last saw the deceased alive on 9-18-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Elijah Saunders		23B. DATE SIGNED 9-20-71	
23C. PHYSICIAN'S NAME (Type) Dr. Elijah Saunders		23D. ADDRESS 2300 Garrison Blvd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-71	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NETTIE FUNERAL HOME		ADDRESS 3035 W. NORTH AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8836

BIRTH NO. 71 8836

1. NAME OF DECEASED
(Type or Print)

Louis Ralph Tucker

2. DATE AND HOUR OF DEATH

9-18-71

9:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL
730 Ashburton St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

3313 Sequoia Avenue

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-23-1922

9. AGE (In years last birthday)

49

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

Water Front

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Newton Tucker

14. MOTHER'S MAIDEN NAME

Blanche Thomas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL SECURITY NO.

150-07-6400

17. INFORMANT

ADDRESS

Mrs. Alice C. Tucker 3313 Sequoia Ave.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute Myocardial Infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notify medical examiner

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-18 19 71 to 9-18 19 71 that (I) (we) last saw the deceased alive on 9-18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gregorio Marfori MD

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9-18-71

23C. PHYSICIAN'S NAME (Type)

DR. GREGORIO MARFORI MD

DEGREE

23D. ADDRESS

730 Ashburton St

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-22-71

24C. NAME of CEMETERY or CREMATORY

St. Luke's Cemetery

24D. LOCATION

(City, town, or county)

Reisterstown

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

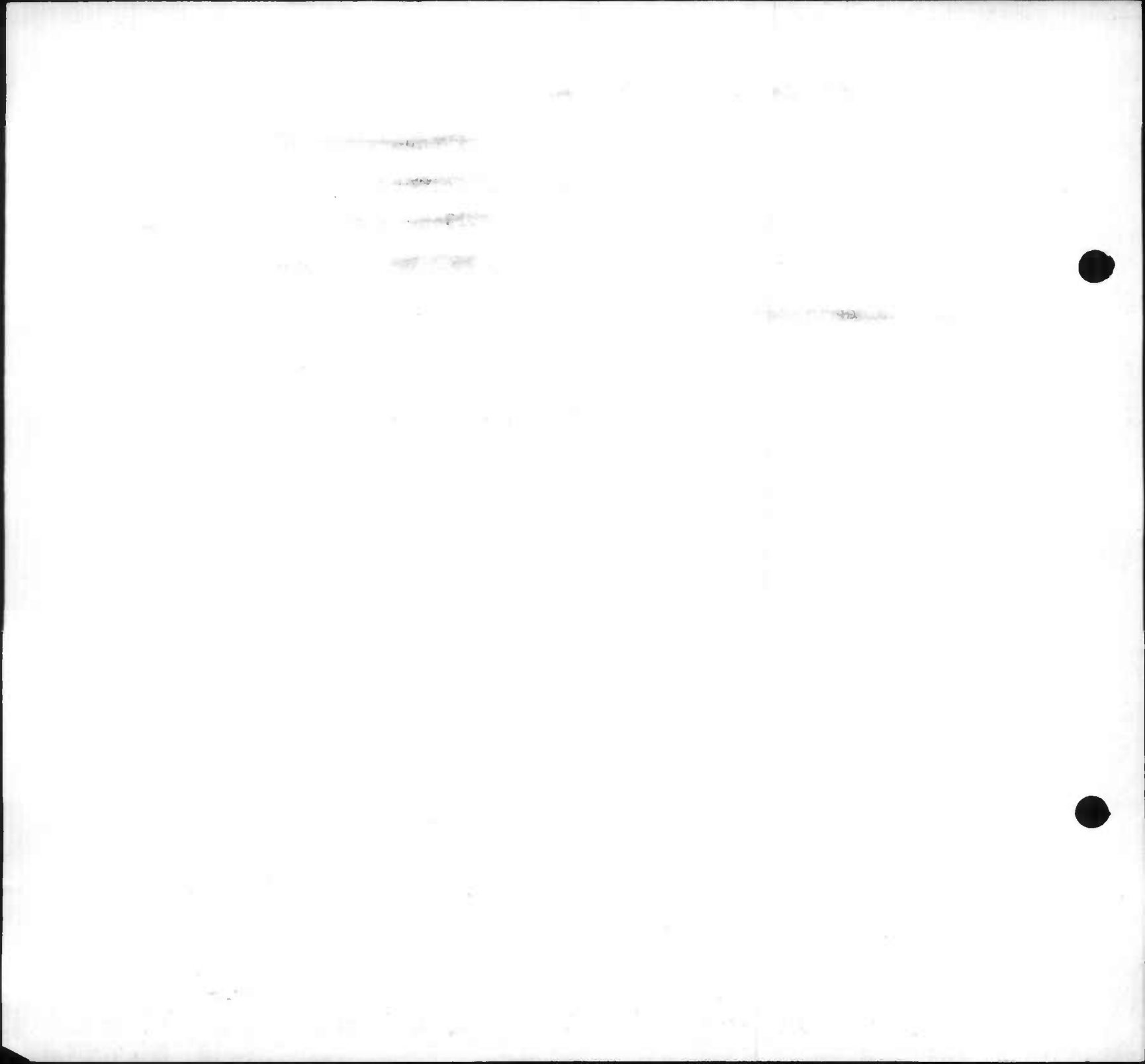
SEP 21 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

UNITED FUNERAL HOME 3035 W. NORTH AVE.



N-350

71 8837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 8837

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Fannie ^{Willie} Newton

2. DATE AND HOUR OF DEATH

9/11/71

8:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Jewish Nursing &
Convalescent Home

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1303

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2431 Woodbrook Ave

5. SEX

6. RACE

F

B

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8/18/98

9. AGE (In years
last birthday)

73

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Latane

14. MOTHER'S MAIDEN NAME

Maggie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-44-

17. INFORMANT

2431 Woodbrook Ave
Mr. Sylvanus Newton (Husband)

18.

486X1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

0297

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

< 24 hours

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Bilateral Cerebral Thromboses 6/10 + 5/11

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/11 8/13 1971 to 9/11 1971
that (I) (we) last saw the deceased alive on 9/11 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Stewart, M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9/11/71

23C. PHYSICIAN'S
NAME (Type)

D. W. STEWART, M.D.

23D. ADDRESS

2300 Garrison Blvd. (21216)

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-16-71

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION

Arbutus

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 21 1971

25B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

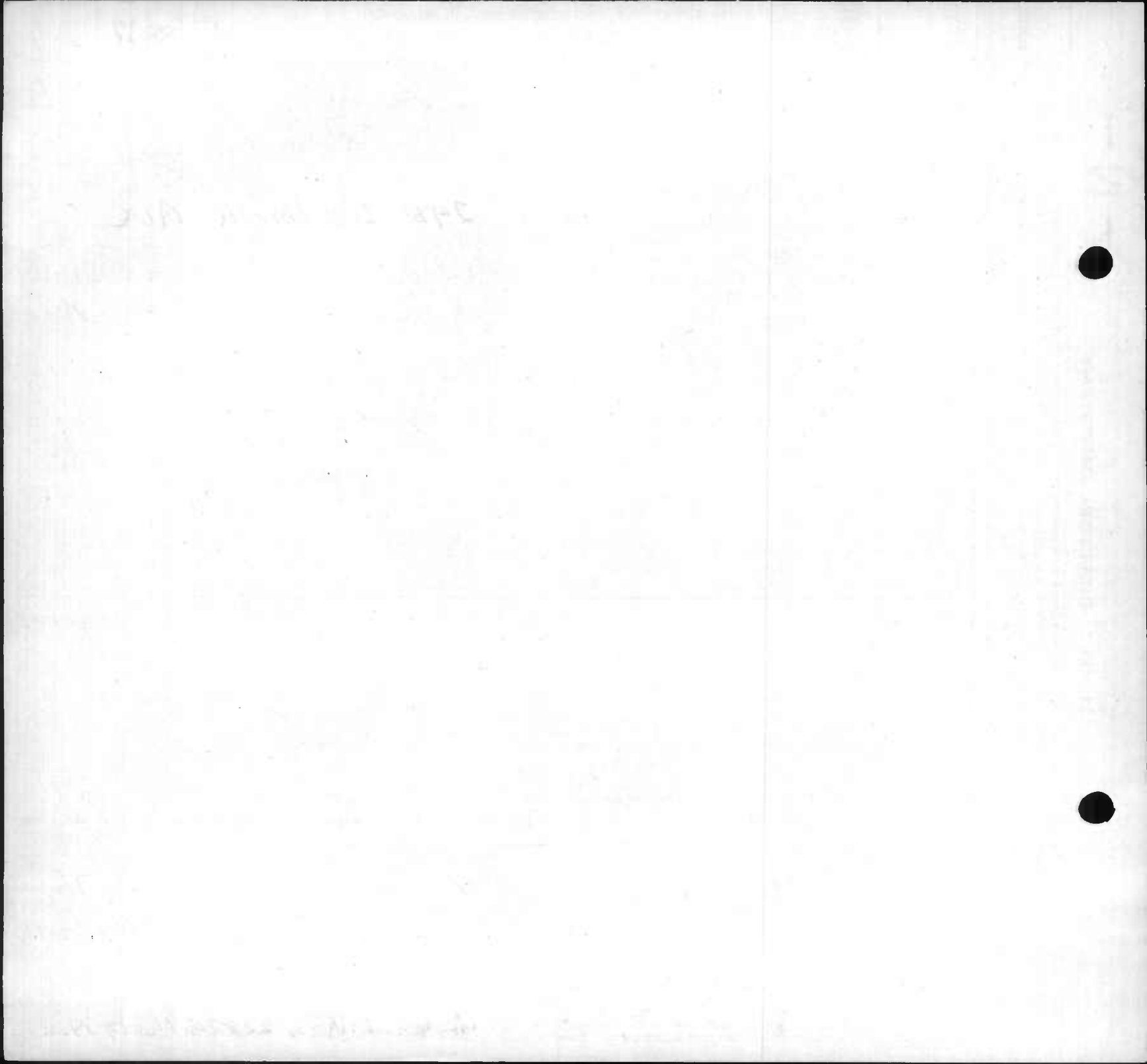
25C. FUNERAL DIRECTOR

Joseph L. Rasmussen 22224 North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



P-456

BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO.		REG. NO.							
71 8838		71 8838							
1. NAME OF DECEASED (Type or Print)					2. DATE OF DEATH				
Ethel Palmer					Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					3. DATE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					Month Day Year Hour				
46 Lutheran Hospital					9 14 71 9:25 A. M.				
6. SEX					5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
Female		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Oct. 1, 1906		64		Annapolis, Md.				Frederick Johnson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
Maid		Dept. Store		Elnora Johnson				215-09-2595	
18. INFORMANT		ADDRESS		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Mrs. Harace Palmer		1736 Warwick Ave.		402X1					
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Hypertensive heart disease	
				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
				ANTECEDENT CAUSES		(B)			
				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.		DUE TO, OR AS A CONSEQUENCE OF:			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
				No					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED 9-14-71									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Werner H. Spitz, M.D.				Burial		9-18-71		Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
SEP 21 1971		V. E. G. G. G. G.		Joseph L. Ruas		2522 W. North Ave.			

ACADEMIC RECORD

WILLIAM K. FORD

1950

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES WILLIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 12 1971 11:15 a.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Apr 7, 1890		10. AGE (In years last birthday) 81	
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. Willis		14. MOTHER'S MAIDEN NAME Jannet Gaskine	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		16. KIND OF BUSINESS OR INDUSTRY Construction	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 220-30-4845	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 412.41 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9/13/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-16-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Men Park		24D. LOCATION (City, town, or county) (State) Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Fisher		ADDRESS 2222 W. North Ave.	

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Dallas, Texas, this 1st day of May, 1904.

Notary Public

My Comm. Expires

ACCORDING TO THE

RECORDS OF THE

NOTARY PUBLIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-3001

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 71 8840		Registered No. 71 8840							
1. NAME OF DECEASED (Type or Print) MARIE MOODY					2. DATE AND HOUR OF DEATH Sept. 19, 1971 11:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Kenesaw Nurs. Home					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1304 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3507 Holmes Ave				
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Feb 22, 1881	9. AGE (in years last birthday) 90	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Charles Green				14. MOTHER'S MAIDEN NAME Margaret Willis				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Helen Gant				ADDRESS 3507 Holmes Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4/10-91 Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH minutes				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Cerebrovascular Arteriosclerosis and generalized Years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/7 19 71 to 9/19 1971, that (I) (we) last saw the deceased alive on Sept. 18 1971 and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.									
23A. SIGNATURE Abram Goldman M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 9/19/71	
23C. PHYSICIAN'S NAME (Type) Abram Goldman					23D. ADDRESS M.D. 4123 FREDERICK AV. BALTO, MD, 21229				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-71		24C. NAME OF CEMETERY OR CREMATORY MT Auburn Cem		24D. LOCATION (City, town, or county) (State) Westport Md			
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph G. Rans			ADDRESS 2222 W. North Ave		

1. 201. When the
 2. 202. When the
 3. 203. When the

4. 204. When the

5. 205. When the

6. 206. When the

7. 207. When the

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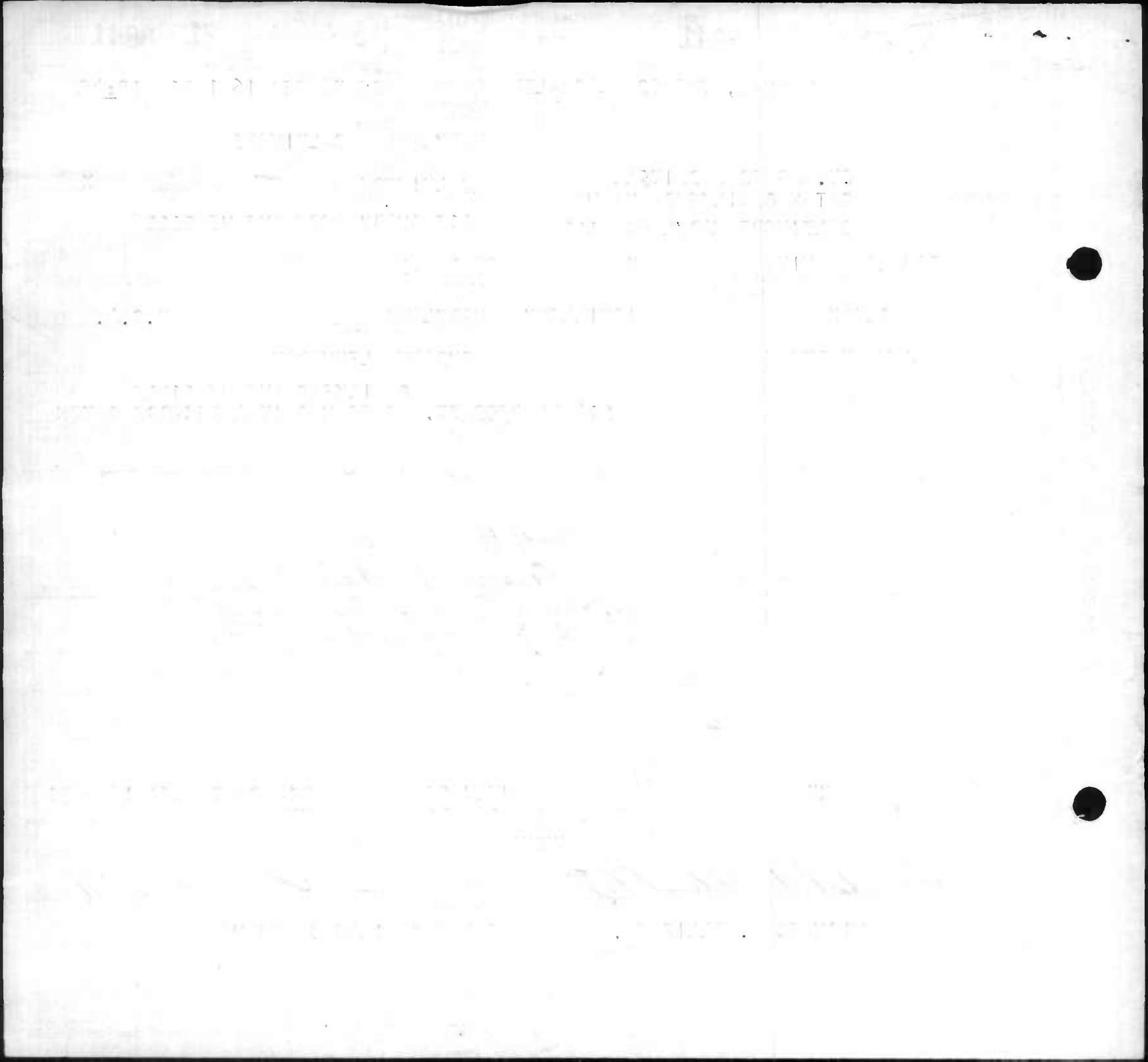
19. 219. When the

20. 220. When the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

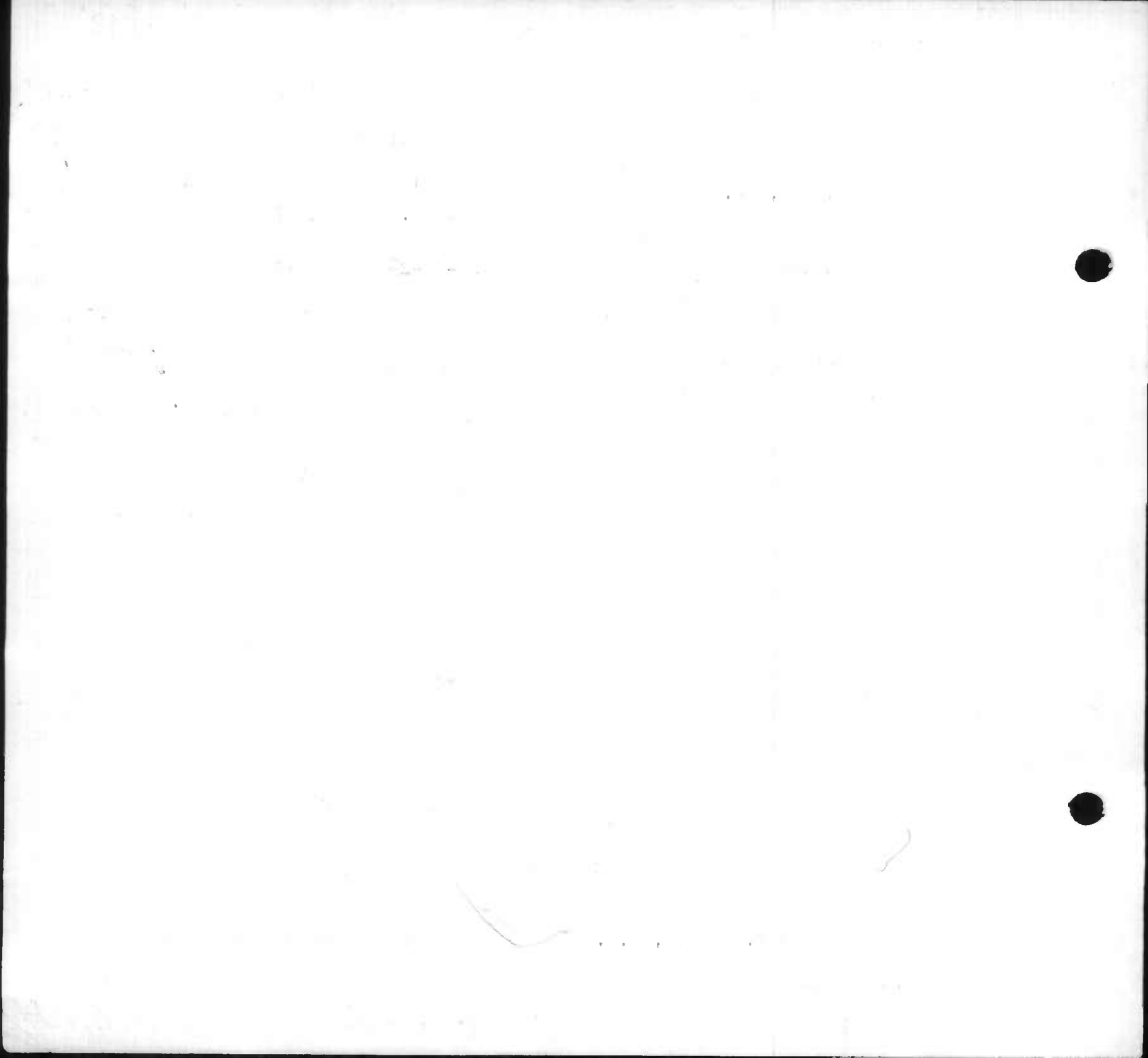
BALTIMORE CITY HEALTH DEPARTMENT		X	
M-624 71 8841		REG. NO. 71 8841	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
MARKEL, THERESA MAGDALEN		SEPTEMBER 16 1971 10:40A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 315 SHADY NOOK AVENUE 21228	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 28 83
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		9B. KIND OF BUSINESS OR INDUSTRY DISTILLERY	9C. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY DISTILLERY	10C. AGE (In years last birthday) 88
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HARTMAN		14. MOTHER'S MAIDEN NAME SUSANNA LENHARDT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 22 4503	
17. INFORMANT & WILKENS AVENUE 21229		ADDRESS CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 7/9/71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of Hip 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH Respiratory Arrest & To Aspiration Cerebral Atherosclerosis Generalized Atherosclerosis Hip Fracture & Chronic Renal Failure & Urinary Tract Infection	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 25 19 71 to SEPTEMBER 16 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 16 1971 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.			
23A. SIGNATURE Michael A. Ellis MD.		23B. DATE SIGNED 9/16/71	
23C. PHYSICIAN'S NAME (Type) MICHAEL A. ELLIS MD.		23D. ADDRESS CATON & WILKENS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/17/71	
24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Taylor Ave Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Frederick D. Miller Inc		ADDRESS 3019 Monument	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-600 71 8842		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8842	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH FARR		2. DATE AND HOUR OF DEATH <i>September 17 1971 10:00P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD. 21213		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 802		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2308 E. FEDERAL STREET		5. SEX MALE		6. RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-01-28		9. AGE (In years lost birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist - Mt Vernon Mills</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>S. Carolina</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Farr</i>		14. MOTHER'S MAIDEN NAME <i>Carrie?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joise Farr - 2308 E. Federal St.</i>	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>MYOCARDIAL INFARCTION</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Sept 17 9pm 1971</i> to <i>Sept 17 10pm 1971</i> that (I) (we) lost saw the deceased alive on <i>Sept 17</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>James F. Martin M.D.</i>		23B. DATE SIGNED <i>9-17-71</i>		23C. PHYSICIAN'S NAME (Type) JAMES F. MARTIN, M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-22-71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Streetport Md.</i>		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971	
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles H. 1129 S. Carolina St.</i>		25D. ADDRESS	



J-52571

8843

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8843

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) PAUL A. JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Balto. Gen. Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 20 1971 7:50 a.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1608	
9. DATE OF BIRTH 10-14-12		10. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Mame		18. INFORMANT Cecelia Johnson	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 9-20-71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-71	
24C. NAME OF CEMETERY or CREMATORY Albion Memorial Park, St. Louis, Mo.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Edwards	
25C. FUNERAL DIRECTOR Edwards		ADDRESS 1129 N. Calhoun St.	

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QAD 000121

VALLEY 21170 20

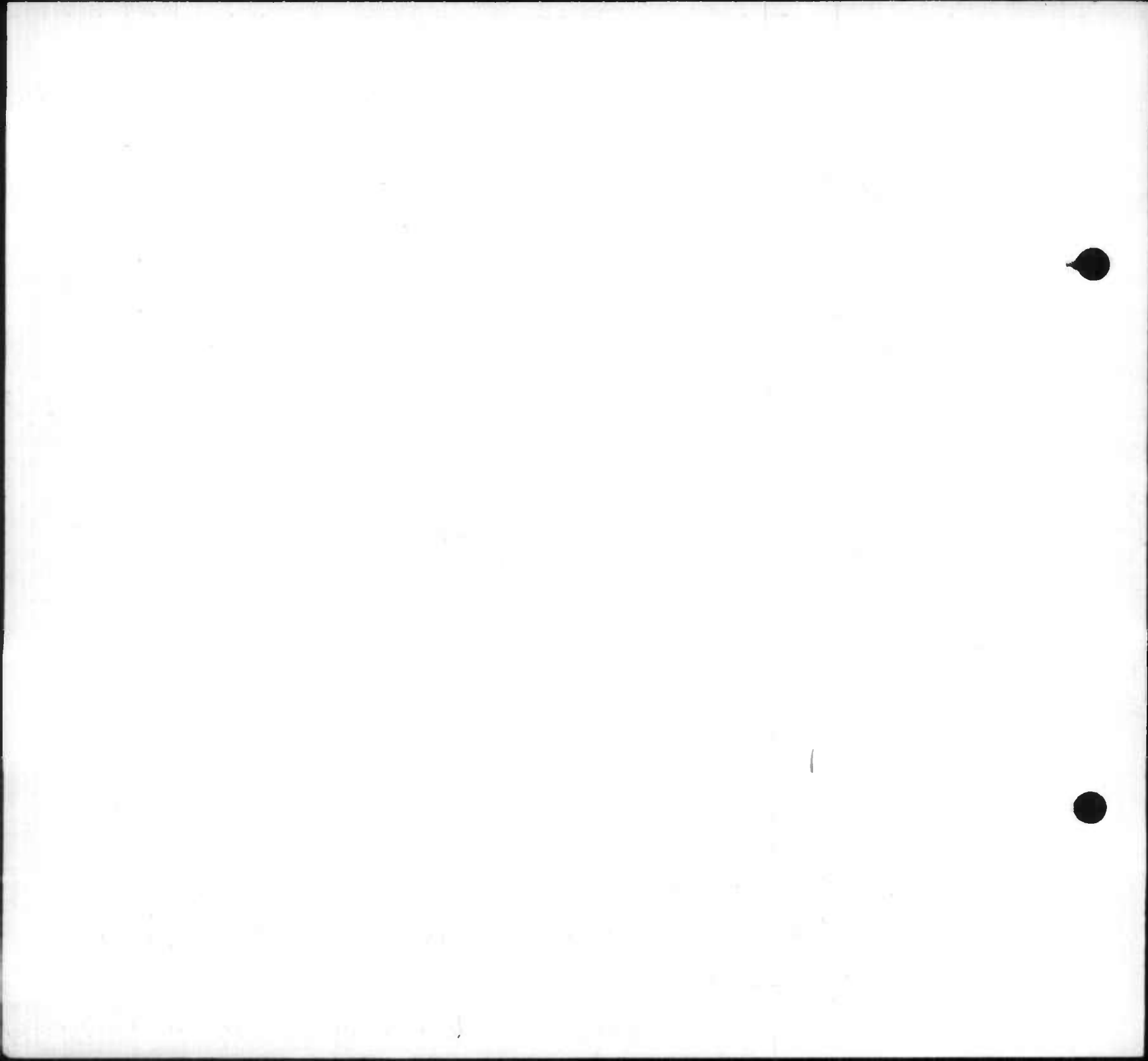
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8844	
BIRTH NO. 71 8844				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Audrey Jackson			2. DATE AND HOUR OF DEATH 9/15/71 13:20 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 45			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 806 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1812 N. Washington Street		
5. SEX Female	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/9/08	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10B. KIND OF BUSINESS OR INDUSTRY V	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Robert Roy		14. MOTHER'S MAIDEN NAME Lucinda (Bowles) Bolden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 216-36-524	17. INFORMANT Hazel Lambert 625 E. 41st St		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.81 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatosis 1969 (B) Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF: 1967 (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. A. Ower M.D.			23B. DATE SIGNED 9/15/71		
23C. PHYSICIAN'S NAME (Type) I. A. Ower M.D.			23D. ADDRESS GOOD SAMARITAN HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Westport, Md.		24E. DATE REC'D BY HEALTH DEPT. SEP 21 1971		24F. NAME OF REGISTRAR Robert E. Fisher, R.D.	
24G. FUNERAL DIRECTOR C. L. H. Funeral Home		24H. ADDRESS 129 N. Calhoun			



71 8845
S-535
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
71 8845
REG. NO.

1. NAME OF DECEASED (Type or Print) HAROLD T. SNOWDEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4709 Old York Road		3. DATE PRONOUNCED DEAD Month Day Year September 19, 1971 2:25 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2739	
9. DATE OF BIRTH 12-27-35		10. AGE (In years first birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Snowden		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor - Electric	
15. MOTHER'S MAIDEN NAME Betty Chase		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1951-1953	
17. SOCIAL SECURITY NO.		18. INFORMANT Caren Snowden	
19. ADDRESS 26 Linworth Ave.			
20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 304.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF:			
22. (B) DUE TO, OR AS A CONSEQUENCE OF:			
23. (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 19, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-71	
24C. NAME OF CEMETERY or CREMATORY Crown Mt Park		24D. LOCATION (City, town, or county) (State) Laurel Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Elbert H. H. 11597		ADDRESS Laurel Md	

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1. NAME OF DECEASED (Type or Print) Boyd Kohler				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 16 71 12:15 P.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 16 71 12:15 P.			
6. SEX male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 20, 1904				10. AGE (In years last birthday) 67		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Kohler			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				15. MOTHER'S MAIDEN NAME Elizabeth Boyd			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 218-14-2224		18. INFORMANT Margaret Kohler Same as #5	
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 9/17/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-71		24C. NAME of CEMETERY or CREMATORY Fairview Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Phoenix Balto., Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. J. [illegible]		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Inc. Towson, Md.			

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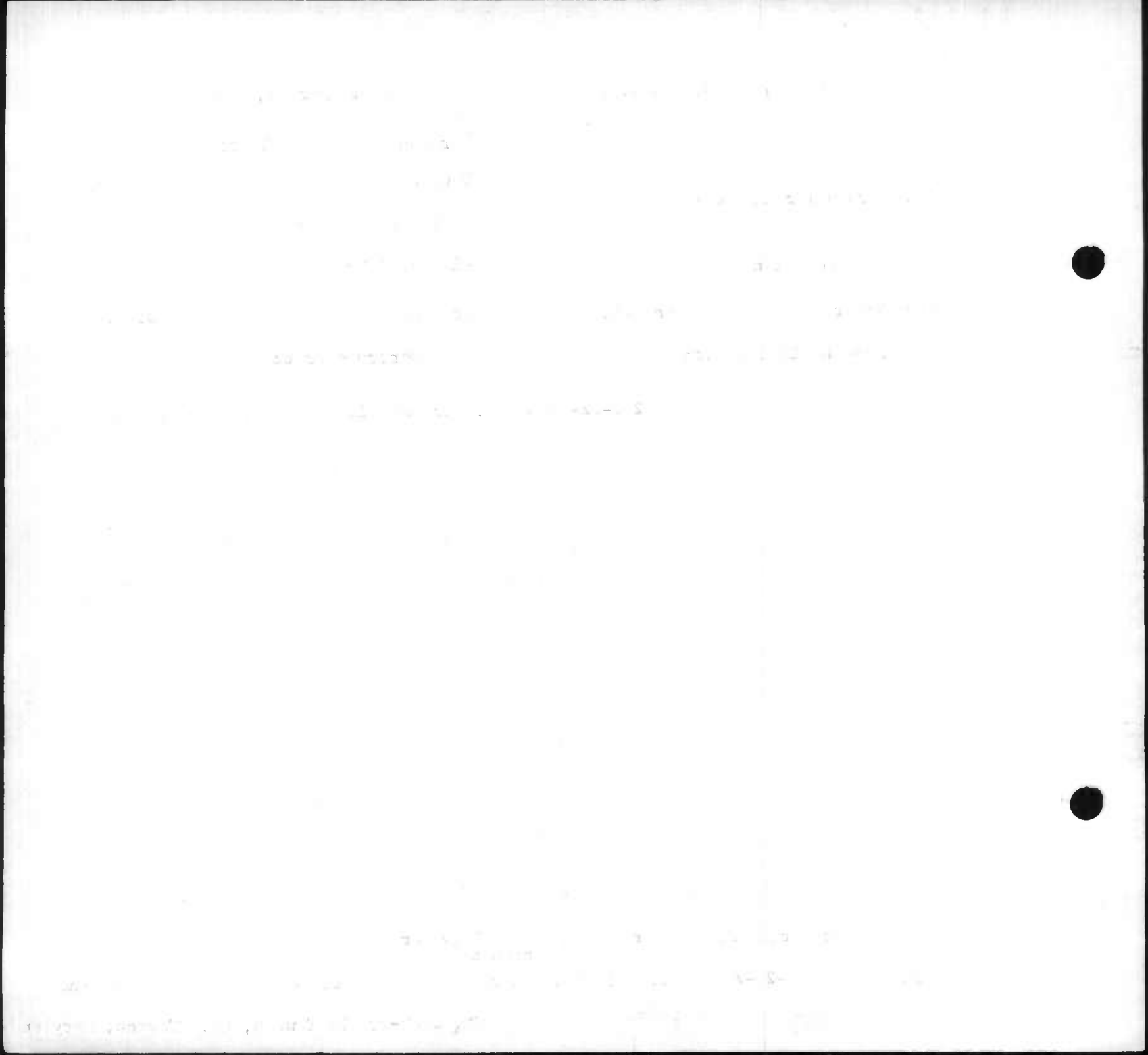
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

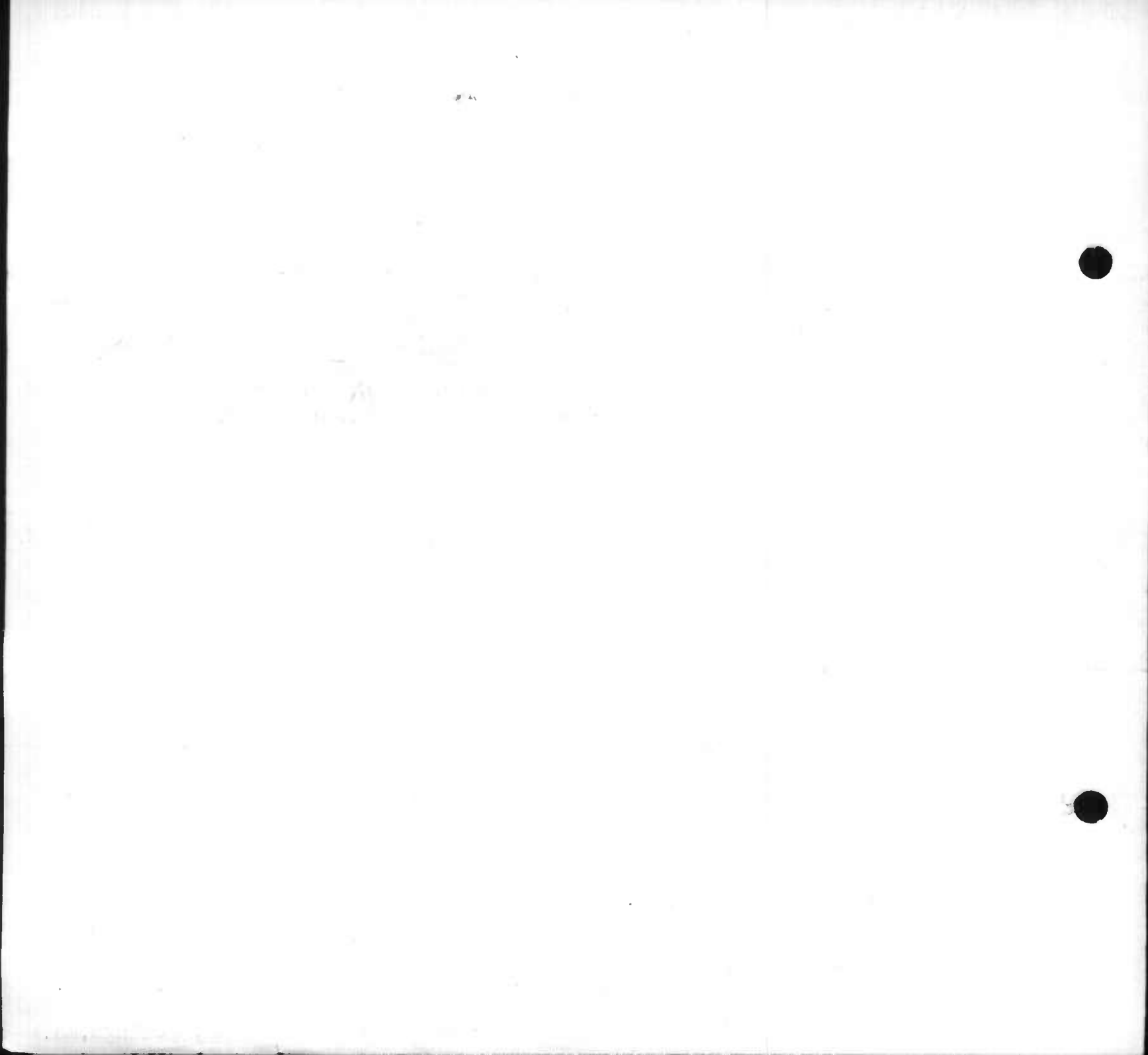
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8847</u>	
7-450 71 8847				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARGARET BELL FALLIN			2. DATE AND HOUR OF DEATH September 18, 1971 7:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1305 Woodshole Road		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1889		9. AGE (In years lost birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph William Kirk			14. MOTHER'S MAIDEN NAME Gertrude Bratt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-8960	17. INFORMANT H. Kirk Fallin ADDRESS Same as # 4 E		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute abdomen - peritonitis				45 hr	
(B) Probable Mesenteric thrombosis DUE TO, OR AS A CONSEQUENCE OF:				48 hr	
(C) Arteriosclerotic CVD				10+ yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9-12-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 19 69 to Sept 18 1971 that (I) (we) last saw the deceased alive on Sept 17 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer M.D.				23B. DATE SIGNED 9-18-71	
23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer M.D.				23D. ADDRESS 6100 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-20-71		24C. NAME OF CEMETERY or INTERMENT Mt. Olivet Cemetery	
24D. LOCATION Baltimore		24E. CITY, TOWN, OR COUNTY Maryland		24F. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks	
25D. ADDRESS Towson, Inc.		25E. CITY, TOWN, OR COUNTY Towson, Maryland		25F. STATE Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

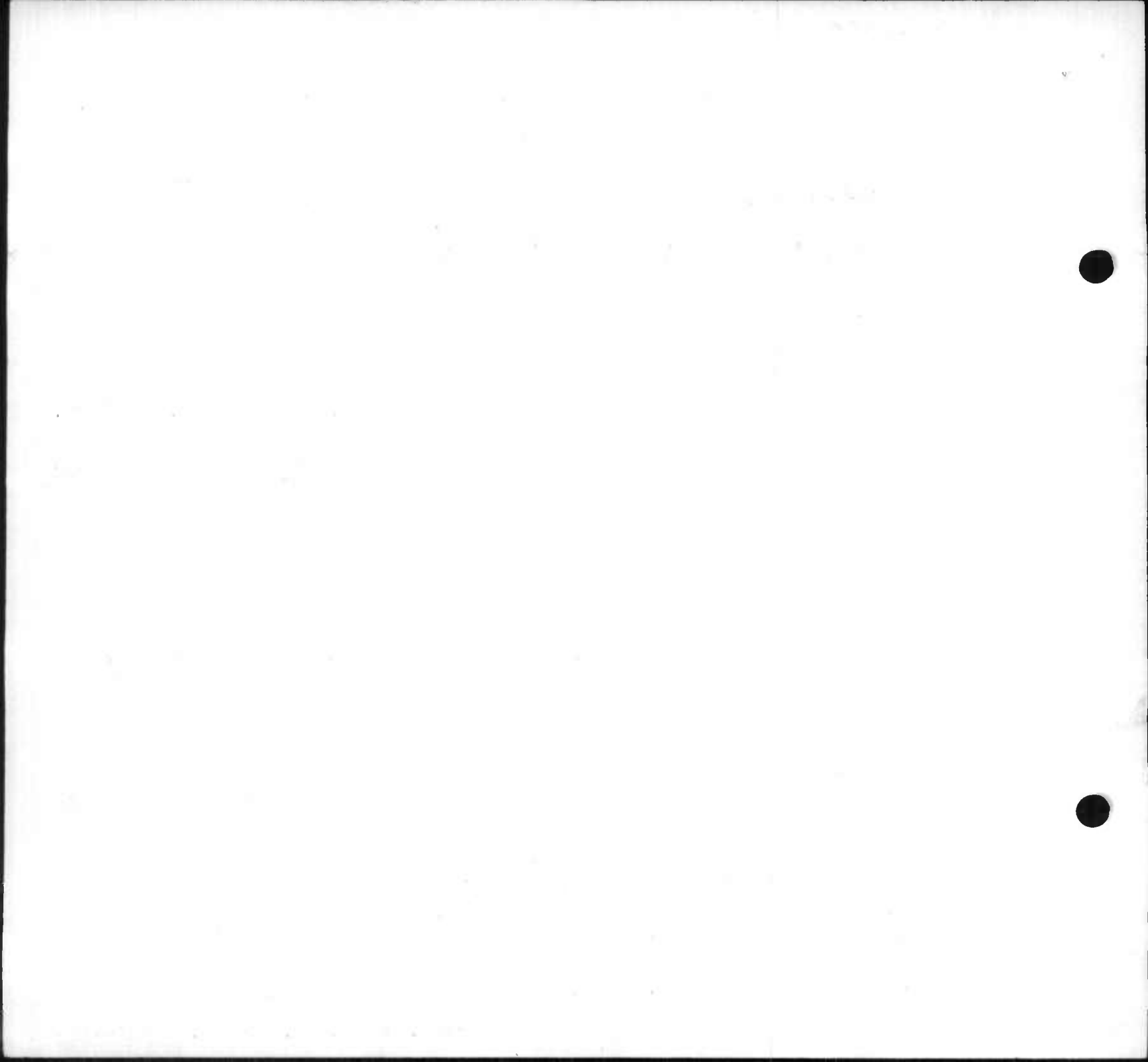
S-500 71 8848		BALTIMORE CITY HEALTH DEPARTMENT		X		71 8848	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Swann, Herbert Harvey</u>				2. DATE AND HOUR OF DEATH <u>9/19/71 7:55</u> A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Carmichael</u> B. COUNTY <u>Calvert</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Maryland Hospital</u> <u>38</u>				C. CITY OR TOWN <u>Owings</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Box 155</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/09</u>	9. AGE (In years lost birthday) <u>61</u>	If Under 1 Yr. Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter R Swann</u>				14. MOTHER'S MAIDEN NAME <u>Susan A. Sunderland</u> Harriet A. Swann			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-36-2552</u>		17. INFORMANT <u>HAZEL M SWANN</u> ADDRESS <u>Wise Owings, Md. (as above)</u>			
18. <u>583X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Rapidly progressive Glomerulonephritis 3 mos.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
				(B) <u>Rapidly progressive Glomerulonephritis 3 mos.</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>8/17/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Biopsy Right Kidney</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> 19 <u>71</u> to <u>9/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Alan G. Stahl, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/19/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan G. Stahl, M.D.</u>				23D. ADDRESS <u>Univ. Hosp. - Dept. of Medicine</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/22/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Southern Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Dunkirk Cal. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>John E. ...</u>		25C. FUNERAL DIRECTOR <u>LUIGI ...</u>		ADDRESS <u>Funeral Home, Owings, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-432 71 8849		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8849	
BIRTH NO.		CERTIFICATE OF DEATH		M	
1. NAME OF DECEASED (Type or Print) <i>Walter J. Schultz</i>		2. DATE AND HOUR OF DEATH <i>September 18, 1971</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31 Baltimore City Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2610</i>			
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>27 S. East Avenue</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/2/'24</i>	9. AGE (In years last birthday) <i>47</i>	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Cutter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Brody Delicatessen</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Joseph Schultz</i>		14. MOTHER'S MAIDEN NAME <i>Clara Piasecki</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>278-76-7059</i>		17. INFORMANT ADDRESS <i>Mrs. Mildred S. Schultz 27 S. East Ave.</i>	
18. <i>398X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>PNEUMONIC PNEUMONIA</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30/18,</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 24</i> 19 <i>61</i> to <i>9/1</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Sept. 7</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Barthelme K. Hyatt</i> M.D. 23B. PHYSICIAN'S NAME (Type) <i>121 S. HIGHLAND AVE</i>				23C. DATE SIGNED <i>9/17/71</i> 23D. ADDRESS <i>121 S. HIGHLAND AVE BALTO. MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/21/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cemetery</i>	
		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE RECEIVED BY HEALTH DEPT. <i>SEP 21 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Naber, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John H. Naber, Inc. 3000 E. Baltimore St.</i>	



FUNERAL DIRECTOR: IMPORTANT

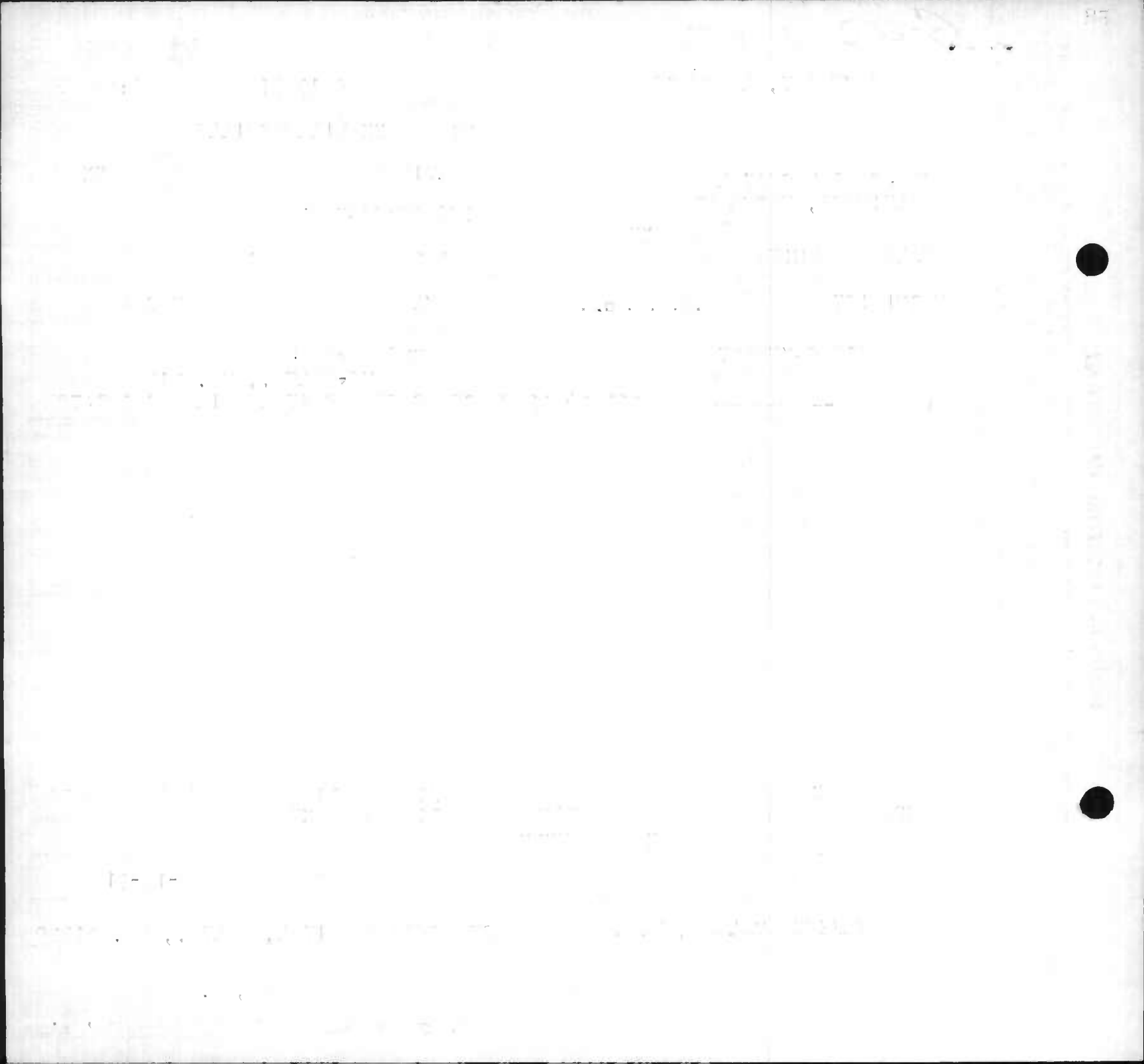
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8850	
BIRTH NO. K-12071 8850					
1. NAME OF DECEASED (Type or Print) Elizabeth J. Kappes				2. DATE AND HOUR OF DEATH 9/20/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 00 3735 Elmona Avenue				A. STATE Maryland B. COUNTY 2643	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3735 Elmona Avenue	
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/89	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10B. KIND OF BUSINESS OR INDUSTRY City Baltimore		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Kavanagh				14. MOTHER'S MAIDEN NAME Anna Cummins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-6401		17. INFORMANT ADDRESS Mr. John P. Kappes 3735 Elmona Avenue	
18. 184.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Uterus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Severe Anemia. Malnutrition				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-19-70 to 9-13-71 that (I) (we) last saw the deceased alive on 9-13-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Niznik M.D.				23B. DATE SIGNED 9-20-71	
23C. PHYSICIAN'S NAME (Type) T. NIZNIK				23D. ADDRESS 29 S. Chester St. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

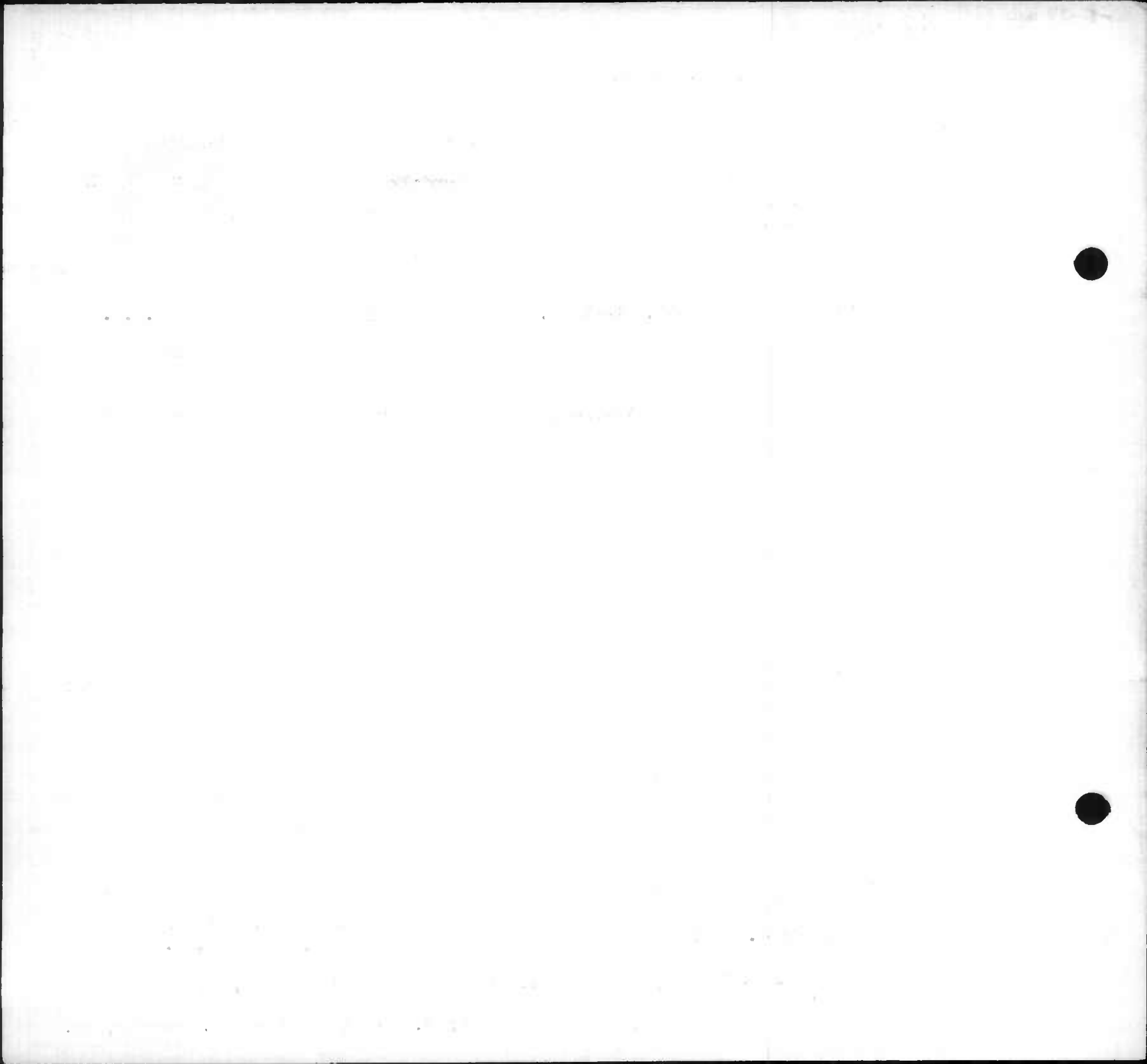
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8851</u>	
G-630		71 8851		71 8851	
1. NAME OF DECEASED (Type or Print) GAYHARDT, LAWRENCE				2. DATE AND HOUR OF DEATH 9/17/71 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY MM MILLERSVILLE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL BALTIMORE, MARYLAND				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 156 OBRECHT RD					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 2 29	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY D.E.P.S. Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME LAWRENCE GAYHARDT				14. MOTHER'S MAIDEN NAME (RETH) HELEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217 24 3380	
				17. INFORMANT AVE-BALTO., MD. 21229 ST AGNES HOSPITAL WILKENS & CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, athermia, etc. It means the disease, injury or complication which caused death.) 2. P.P.O. I Lobar pneumonia, bilateral organism: candida albicans DUE TO, OR AS A CONSEQUENCE OF: Lymphosarcoma stage IV Agamulocytosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 8/10 1971 to 9/17/ 19 71 that (X) (we) last saw the deceased alive on 9/17 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE <i>Perfecto Valaro</i>				23B. DATE SIGNED 09-18-71	
23C. PHYSICIAN'S NAME (Type) PERFECTO VALARO, M.D.				23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.					
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Singleton Funeral Home	
				ADDRESS Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

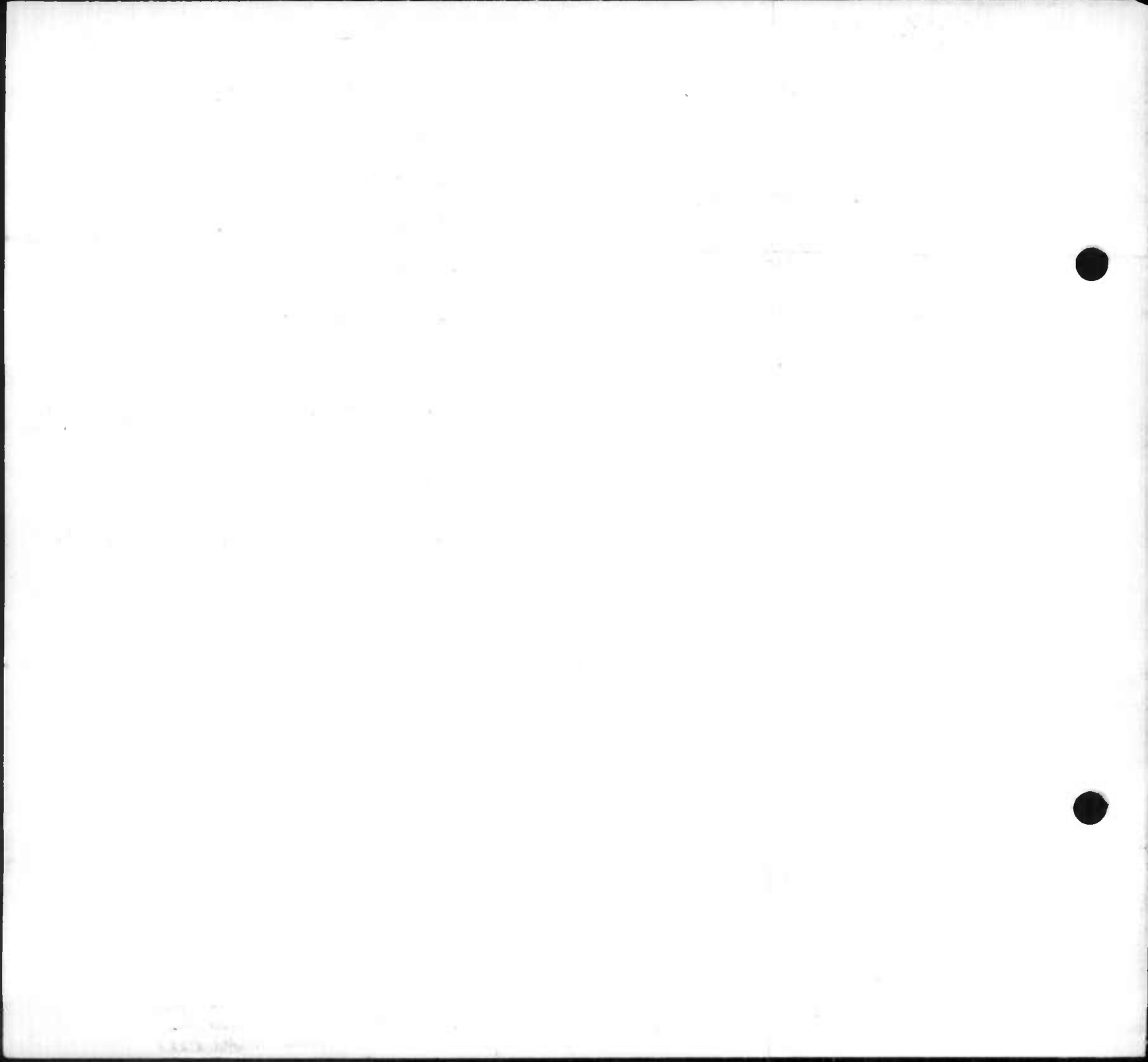
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-246 71 8852		BALTIMORE CITY HEALTH DEPARTMENT		X		CERTIFICATE OF DEATH		REG. NO. 71 8852	
1. NAME OF DECEASED (Type or Print) <u>Keith E. McElroy</u> <u>Keith McElroy</u>				2. DATE AND HOUR OF DEATH <u>9/18/71</u> <u>7:45</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>6925 Broening Road 21222</u>					
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-5-1907</u>		9. AGE (In years last birthday) <u>64</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Repair Shop</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judson</u>				14. MOTHER'S MAIDEN NAME <u>Rena Taylor</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-2149</u>		17. INFORMANT <u>Records: BCH-4940 Eastern Avenue 21224</u>			
18. <u>201X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Hodgkin's Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Marie - Strumpell spandylitic</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>8</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>March 19 66</u> to <u>9/18</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Kevin J. Hunt MD</u>				23B. DATE SIGNED <u>9/18/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Kevin J. Hunt</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-20-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holly Hill Mem. Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>White Marsh, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>		25D. ADDRESS <u>922 Wise Ave. Dundalk, Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

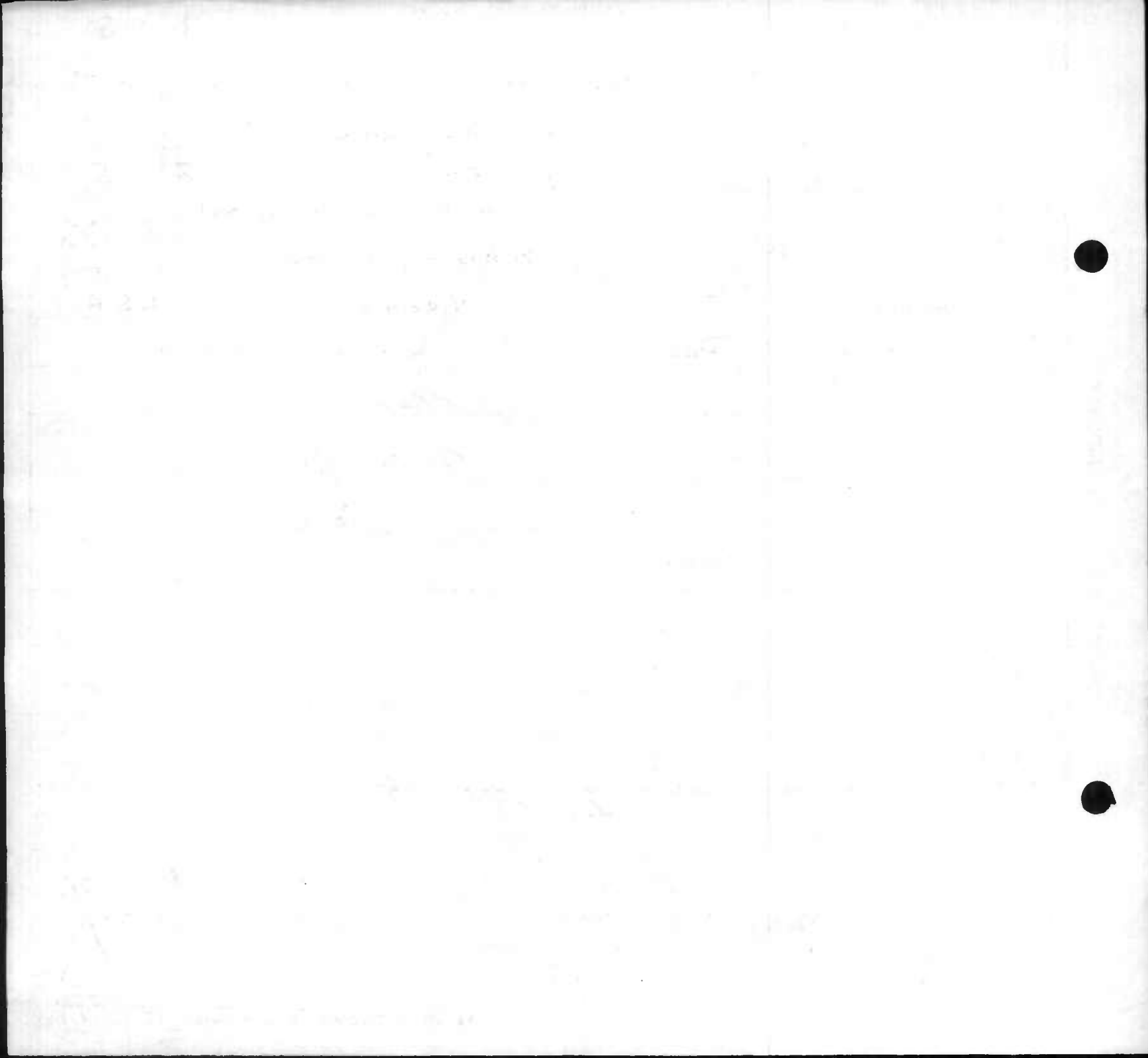
C-230		71 8853		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8853	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOSEPH F. CASSIDY			
2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1971 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Catonsville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 6141 Regent Park Rd.	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1917	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager			10B. KIND OF BUSINESS OR INDUSTRY American Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph S. Cassidy				14. MOTHER'S MAIDEN NAME Marie Weyrauch			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 219-05-8126		17. INFORMANT Mrs. Doris G. Cassidy		ADDRESS 6141 Regent Park Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Due to, or as a consequence of: Acute Coronary		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
(B) Previous Coronary Artery disease Due to, or as a consequence of: 9 years.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James E. Deane M.D.				23B. DATE SIGNED 9-17-71		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9/20/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland				24E. DATE REC'D BY HEALTH DEPT. SEP 21 1971		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR St. Agnes Hosp. Baltimore 21229 (GR)				24H. ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8854</u>	
P-620 71 8854					
BIRTH NO. <u>1</u>					
1. NAME OF DECEASED (Type or Print) <u>JACK PARRIS PARRIS</u>			2. DATE AND HOUR OF DEATH <u>SEP 17 1971</u> <u>8 20</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2505</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore Gen Hospital</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3800 FAIRHAVEN AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29, 1921</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>HENRY O. PARRIS</u>		
14. MOTHER'S MAIDEN NAME <u>Lithia RYAN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Chant</u>		
18. <u>571.71</u>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC FAILURE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Liver embolism</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEP 16 1971</u> to <u>SEP 17 1971</u> that (I) (we) last saw the deceased alive on <u>SEP 17 1971</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Yung Soo PANG</u>				23B. DATE SIGNED <u>9/17/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Yung Soo PANG</u>				23D. ADDRESS <u>South Bal Gen Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-19-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>GREENFIELD Baptist Crem.</u>	
24D. LOCATION (City, town, or county) <u>Chilhowie</u>		24E. ADDRESS <u>1050 YORK RD. TOWSON, MD.</u>		24F. ADDRESS <u>1050 YORK RD. TOWSON, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1971</u>		25B. NAME OF REGISTRAR <u>W. Cook</u>		25C. FUNERAL DIRECTOR <u>Belts Towson, Inc.</u>	



FUNERAL DIRECTOR: IMPORTANT

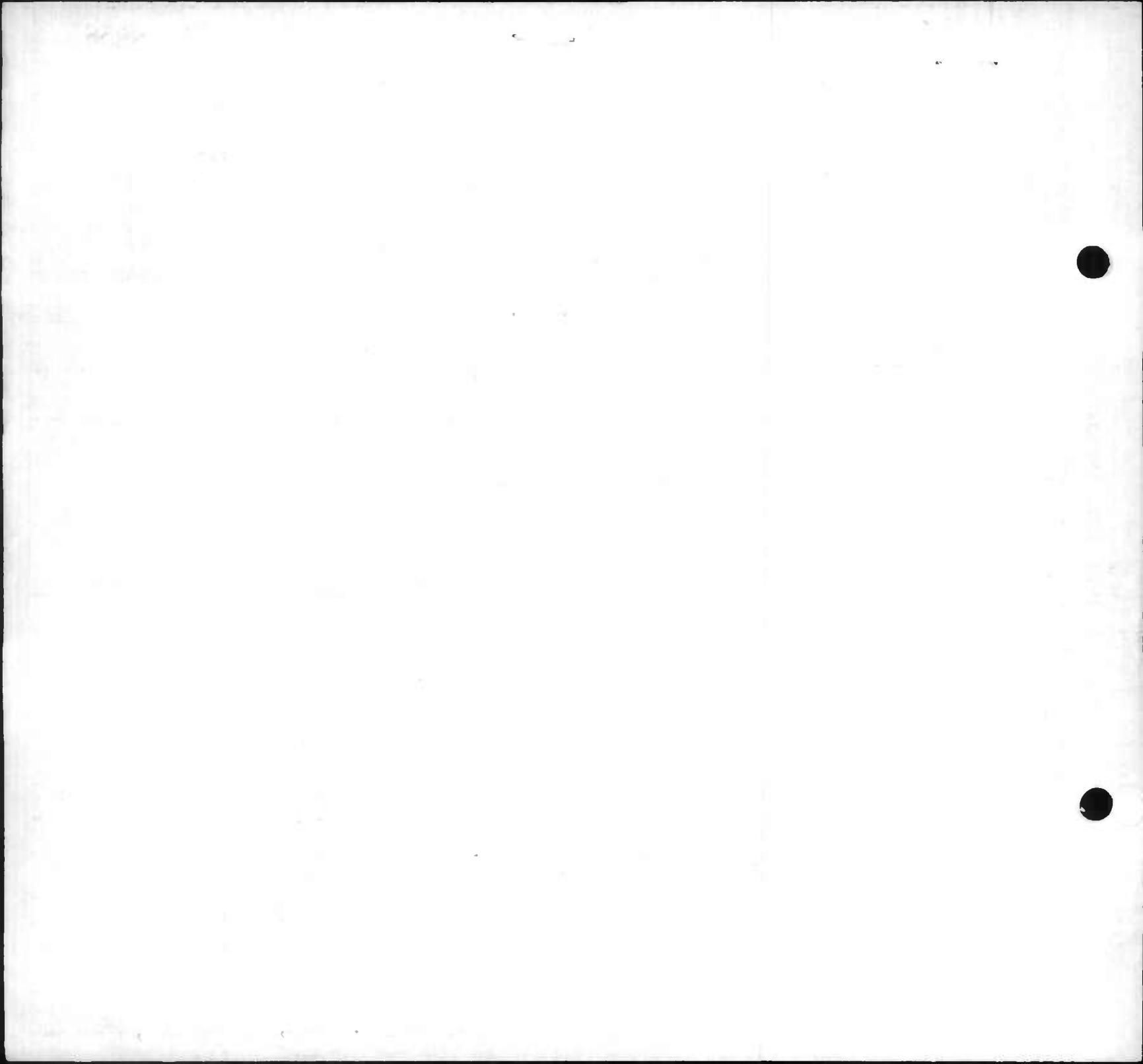
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-000 71 8855		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8855	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DESSIE PEARL DYE		2. DATE AND HOUR OF DEATH SEPT. 17, 1971 17:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD +9 NORTH CHARLES GENERAL HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE (DUNDALK)		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION +9 NORTH CHARLES GENERAL HOSP.		E. STREET AND NUMBER 2927 YORKWAY			
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/94	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR MURRAY		14. MOTHER'S MAIDEN NAME Rebecca McKinney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-05-5508		17. INFORMANT North Charles General Hospital Chart	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain malignancy ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Left lung malignancy (B) (adenocarcinoma) (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent ?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 8, 1971 to September 17, 1971 that (we) last saw the deceased alive on September 17, 1971 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Rufino G. Montenegro M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) RUFINO G. MONTENEGRO M.D.	
23D. ADDRESS NORTH CHARLES AND 28th ST. BALTO. MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-71		24C. NAME OF CEMETERY or CREMATORY East Oak Grove Cemetery	
24D. LOCATION (City, town, or county) (State) Mongantown, Monongalia Co. W. Va.					
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1971		25B. NAME OF REGISTRAR Rufino G. Montenegro		25C. FUNERAL DIRECTOR John J. Duda	
25D. ADDRESS Funeral Home 7922 Wise Dundalk, Md.					

15 49 11 5

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

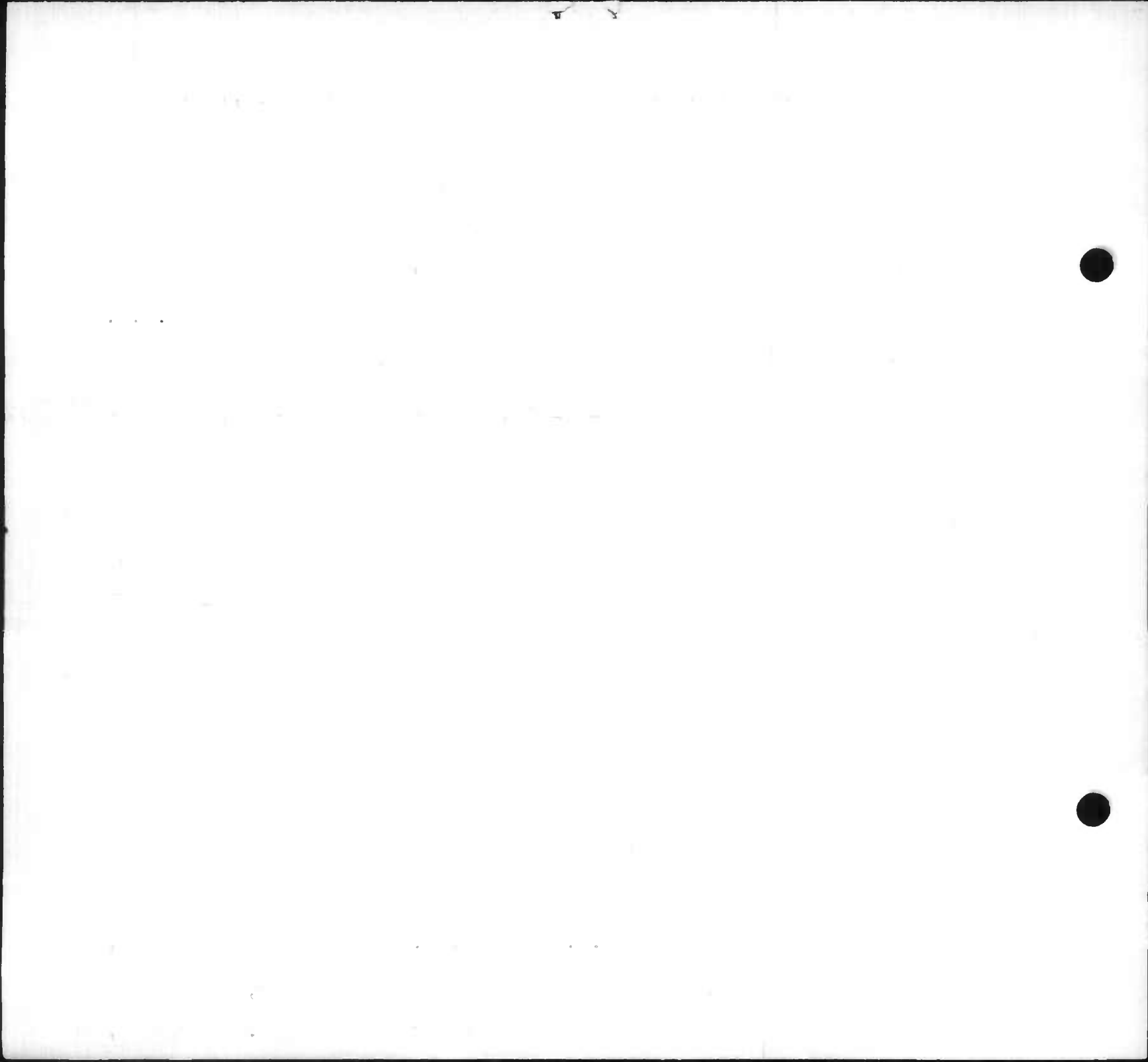
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8856</u>	
7-410 71 8856				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>GEORGE FIBEY</u>			2. DATE AND HOUR OF DEATH <u>9-20-71</u> <u>2.30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2745</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6000 EDNA AVENUE</u> <u>21214</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1899</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas & Elect. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Edwin Filbey</u>			14. MOTHER'S MAIDEN NAME <u>Lyda (Akehurst)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212 05 3986</u>		17. INFORMANT <u>Mrs Bertha Filbey</u>	
				ADDRESS <u>6000 Edna Ave #14</u>	
18. <u>7-410-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>EXSANGUINATION</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>RUPTURED AORTIC ABDOMINAL ANEURYSM 5 days</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9-20-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RUPTURED ANEURYSM</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) Month (Day) Year Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>71</u> to <u>9/20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. J. Helou</u> M.D.			23B. DATE SIGNED <u>9-20-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Alan C. Woods Jr. M.D.</u> <u>A. J. HELOU</u> M.D.			23D. ADDRESS <u>550 North Broad St.</u> <u>UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9 23 71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	
24D. LOCATION <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leopold J. Bruck, Inc</u>	
				ADDRESS <u>Balto, Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

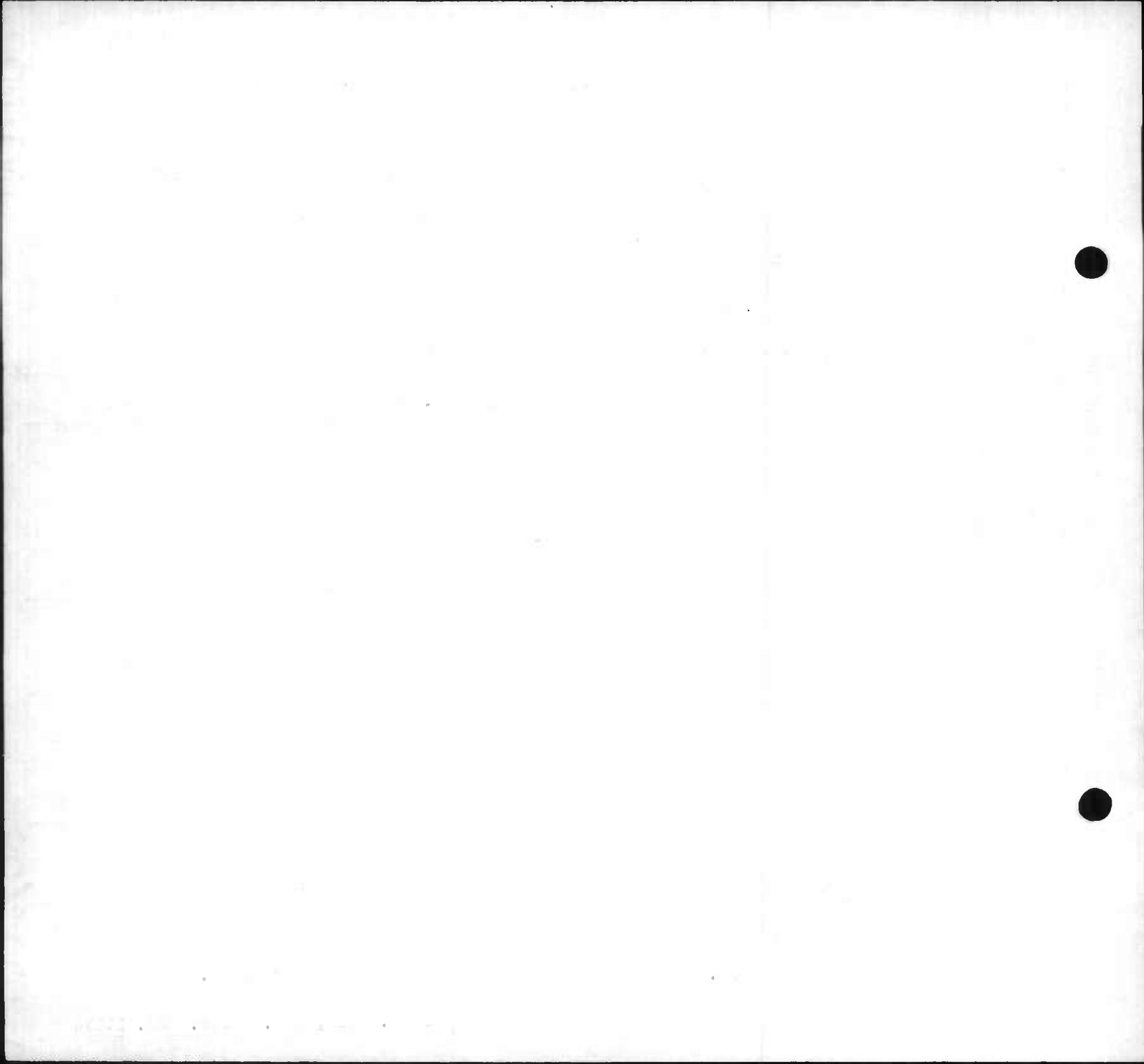
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8857</u>	
BIRTH NO. <u>S-263 71 8857</u>					
1. NAME OF DECEASED (Type or Print) <u>Louisa R Schuckert</u>			2. DATE AND HOUR OF DEATH <u>September 19, 1971 6:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>3205 Batavia Ave</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2743</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3205 Batavia Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1894</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Conrad Miller</u>			14. MOTHER'S MAIDEN NAME <u>Anna Gering</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-46-1231</u>		17. INFORMANT <u>Mr Charles R Little</u>
			ADDRESS <u>Valley 1802 Dulaney Valley</u>		
18. <u>4317 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-10-71</u> 19 <u>71</u> to <u>August 25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>August 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Melito M. Torres, M.D.</u>				23B. DATE SIGNED <u>9-21-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Melito M Torres M.D.</u>				23D. ADDRESS <u>441 S. Ellwood Ave Baltimore, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/22/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>			
25B. NAME OF REGISTRAR <u>Leonard J Ruck Inc.</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Md</u>			



FUNERAL DIRECTOR: IMPORTANT

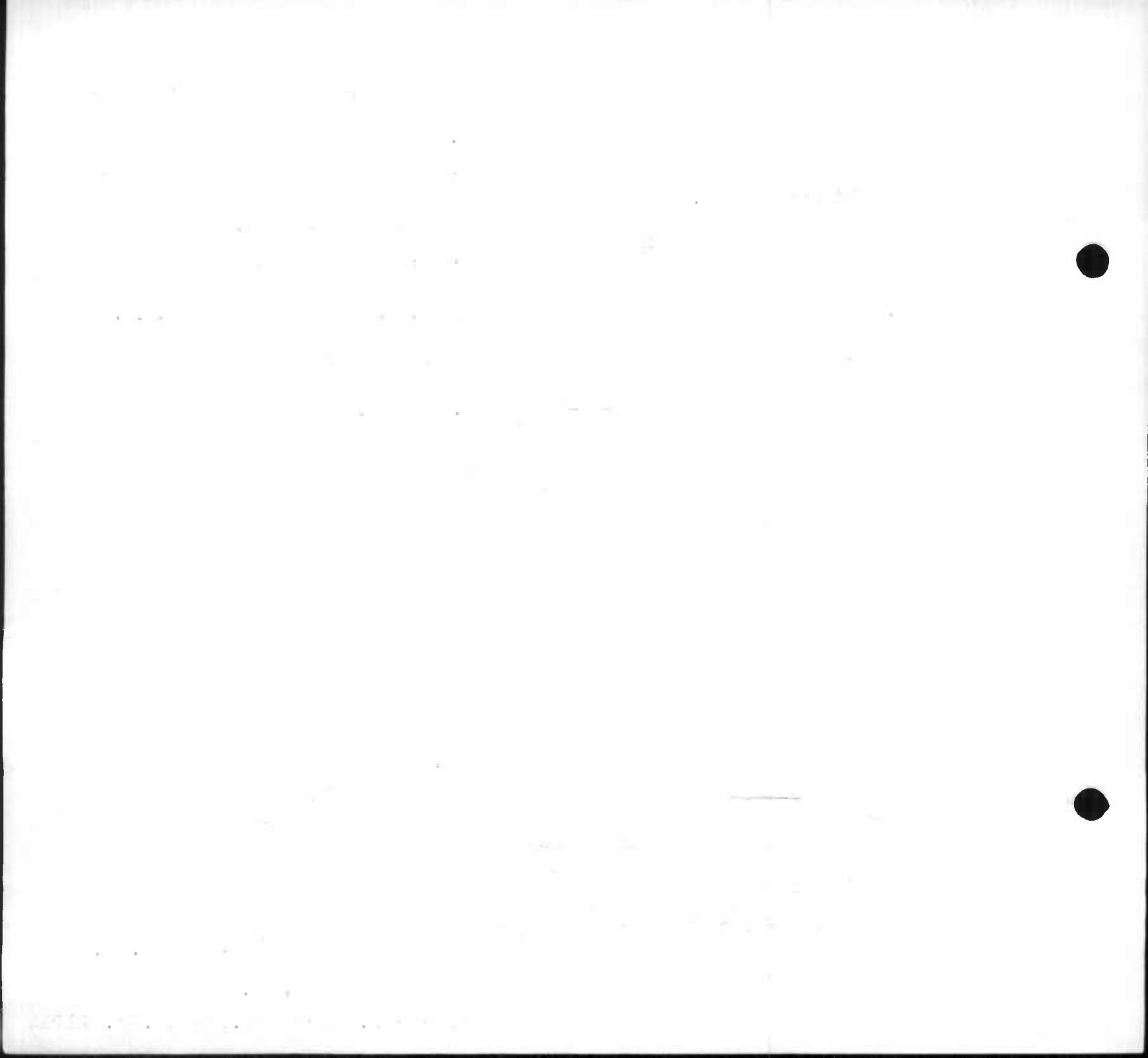
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8858</u>	
BIRTH NO. <u>71 8858</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HARVEY B. REMBOLD</u>		2. DATE AND HOUR OF DEATH <u>9/20/71</u> <u>4 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>904</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2918 INDEPENDENCE ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-94</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES REMBOLD</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth CAGE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-8358</u>		17. INFORMANT <u>Mrs. Margaret Rembold</u> ADDRESS (Same)	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIAC ASYSTOLE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>G.I. Bleeding</u>					
19A. DATE OF OPERATION <u>9-10-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ABDOMINAL ANEURYSM</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-10</u> 19 <u>71</u> to <u>9-20</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. J. Helou, M.D.</u>		23B. DATE SIGNED <u>9-20-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>A. J. HELOU, M.D.</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>John A. Johnson</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

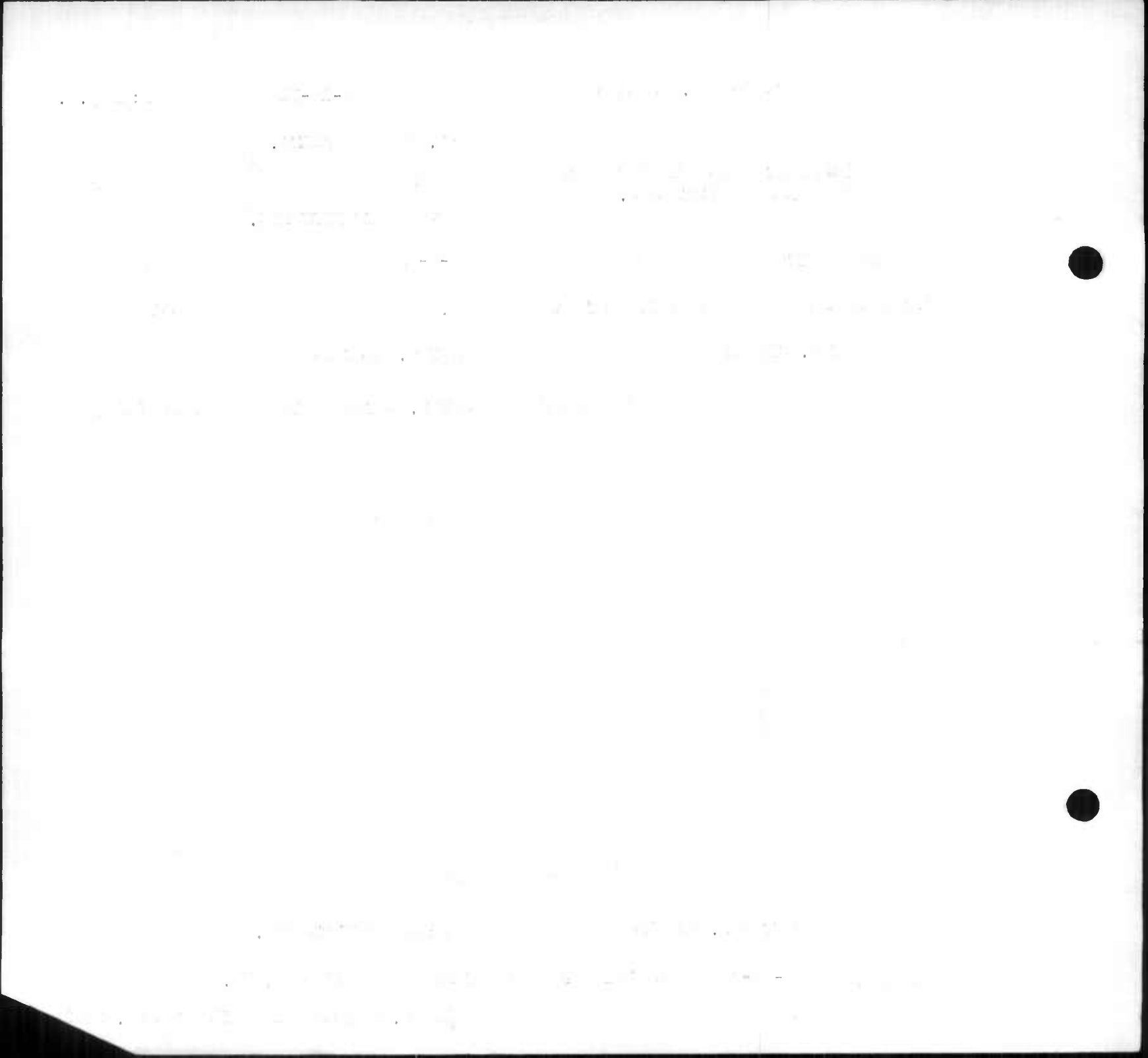
N-160 71 8859		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8859	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN F. NEUBAUER		September 20, 1971 5 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY		2738	
1443 Cedarcroft Rd.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		1443 Cedarcroft Rd.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 25, 1895	75	11. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret.		Interior Decorator		Balto. Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John E. Neubauer		Mary Leoffer		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216-05-4122		Mrs. Grace B. Neubauer Same as Above	
18. 436.4		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cerebrovascular Accident 1 month	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 19 1971 to Sept 20 1971 that (I) last saw the deceased alive on Aug 19 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph F. L. Piram M.D.		9/20/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSEPH F. L. PIRAM M.D.		8400 Loch Raven Blvd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/23/71		Gardens of Faith	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 22 1971		Leonard J. Ruck Inc., Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-15271 8860		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8860	
1. NAME OF DECEASED (Type as Print) GEORGE L. SPENCE			2. DATE AND HOUR OF DEATH 9-18-71 5:15 p.m. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PLEASANT MANOR NURSING HOME 4615 PARK HEIGHTS AVE.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO.		
			C. CITY OR TOWN WOODLAWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 6027 MONTGOMERY AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-95	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN STORES		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JOHN S. SPENCE			14. MOTHER'S MAIDEN NAME MARY C. HARTMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217037704		17. INFORMANT MARY S. WATERS 814 COOKS LANE 21229	
18. I 1759 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Ca morte, fibrosarcoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mild Emphysema (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/22/1971 to 9/18/71 19 71 that (I) (we) last saw the deceased alive on 9/18/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathan E. Needle			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) NATHAN E. NEEDLE			23D. ADDRESS 7111 PARK HEIGHTS AVE.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-21-71		24C. NAME of CEMETERY or CREMATORY LORRAINE PARK CEMETERY	
24D. LOCATION BALTIMORE, MD.					
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

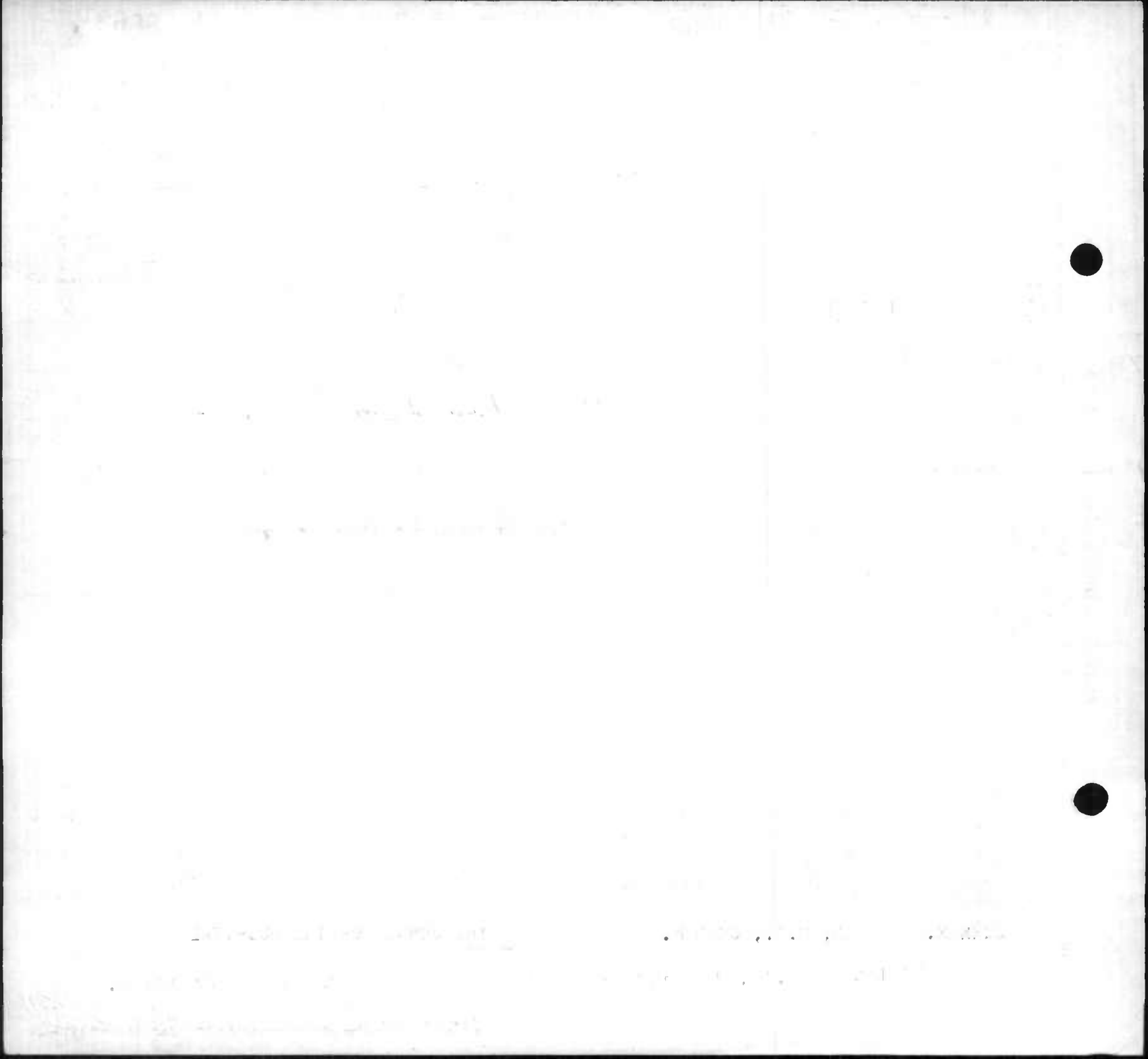
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8861</u>	
<u>W-452</u> BIRTH NO. <u>71 8861</u>		1. NAME OF DECEASED (Type or Print) <u>Ernest F. Williams</u>		2. DATE AND HOUR OF DEATH <u>9/20/71</u> <u>6 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 906 Ramsay St.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>906 Ramsay St.</u>		
5. SEX <u>M.</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/1905</u> 9. AGE (In years last birthday) <u>65</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>D. & O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>? Williams</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Anna B. Williams</u> ADDRESS <u>Above</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>EXSANGINATION 20 to</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY HEMORRHAGE 20</u> (B) <u>SUSPECTED RUPTURE PULMONARY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERY DUE TO</u> (C) <u>BROCHOCARCINOMA</u> <u>OF RIGHT LUNG</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-1-</u> 19 <u>70</u> to <u>9-20-</u> 19 <u>71</u> that (I) (lost) saw the deceased alive on <u>9-14-71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <u>Bald. Kyrus / MD</u>				23B. DATE SIGNED <u>9-21-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>BERNARD S. KARPENS JR MD</u>				23D. ADDRESS <u>514 MEDICAL ARTS BLDG. BACTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>John J. Conway & Son Inc.</u> ADDRESS <u>Hollins St. 23rd Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

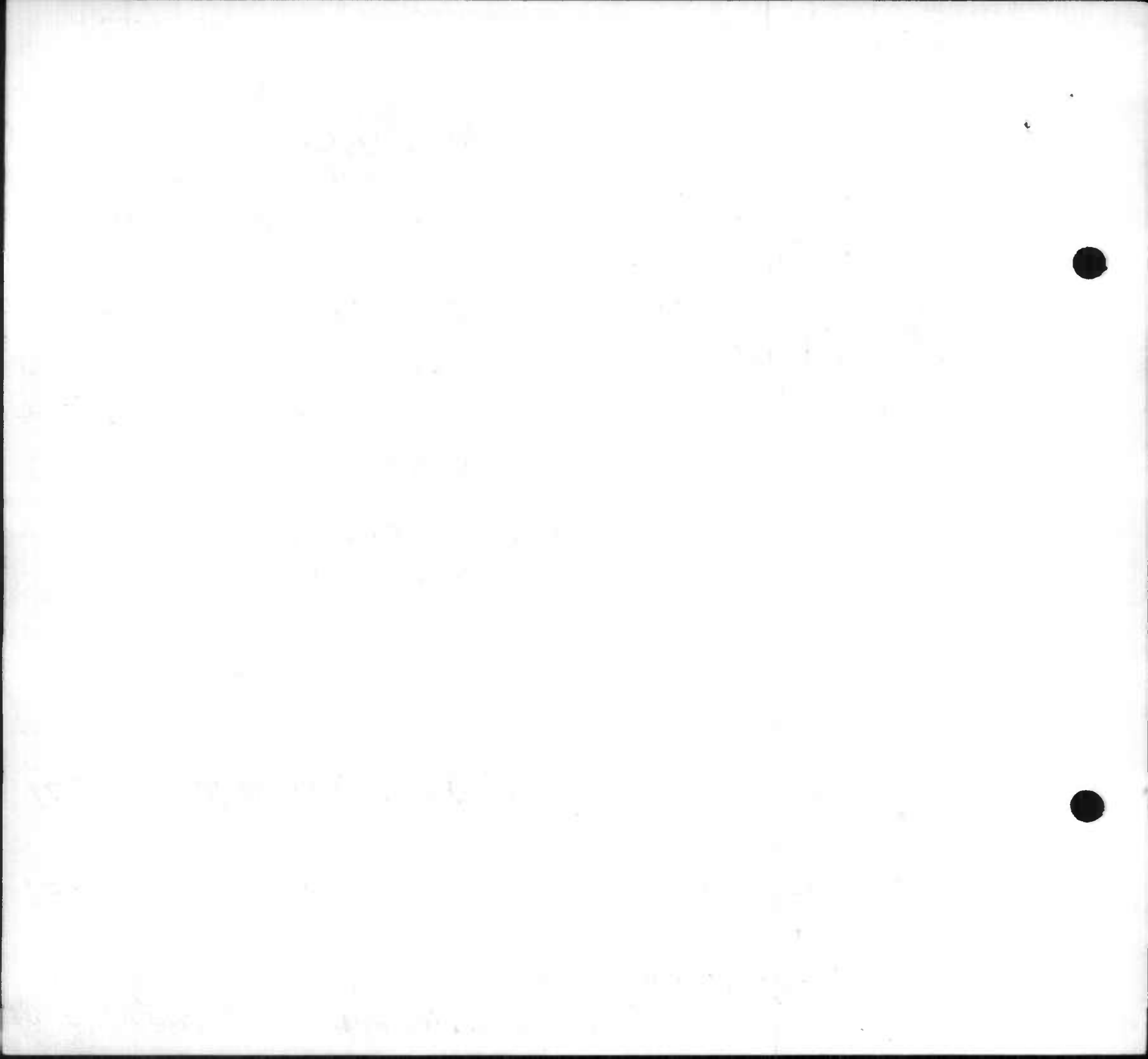
BALTIMORE CITY HEALTH DEPARTMENT				X		71 8862	
7-565 71 8862				REG. NO.		71 8862	
BIRTH NO. <u>Hagerstown, Md.</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Elizabeth Ann Zimmerman</u>				2. DATE AND HOUR OF DEATH <u>September 17-71 735 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>WASH</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>33 Baltimore, Maryland</u>				C. CITY OR TOWN <u>Hancock</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Route 1</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/71</u>		9. AGE (In years last birthday) <u>4 days</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington County Hospital</u> <u>Hagerstown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Curt Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>CAROL Singleton</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes <input type="checkbox"/> or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Bert A Zimmerman</u> ADDRESS <u>Route 1 Hancock Md</u>			
18. <u>743.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CAUSE OF DEATH</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
				(B) <u>Encephalocoele & Meningocele</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> 19 <u>71</u> to <u>9/17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>John M. Freeman</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/17/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN M. FREEMAN</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9.19.71</u>		24C. NAME OF CEMETERY or CREMATORY <u>PLESANT GROVE</u>		24D. LOCATION (City, town, or county) (State) <u>FULTON COUNTY PENNA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>John E. ...</u>		25C. FUNERAL DIRECTOR <u>Harold ...</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

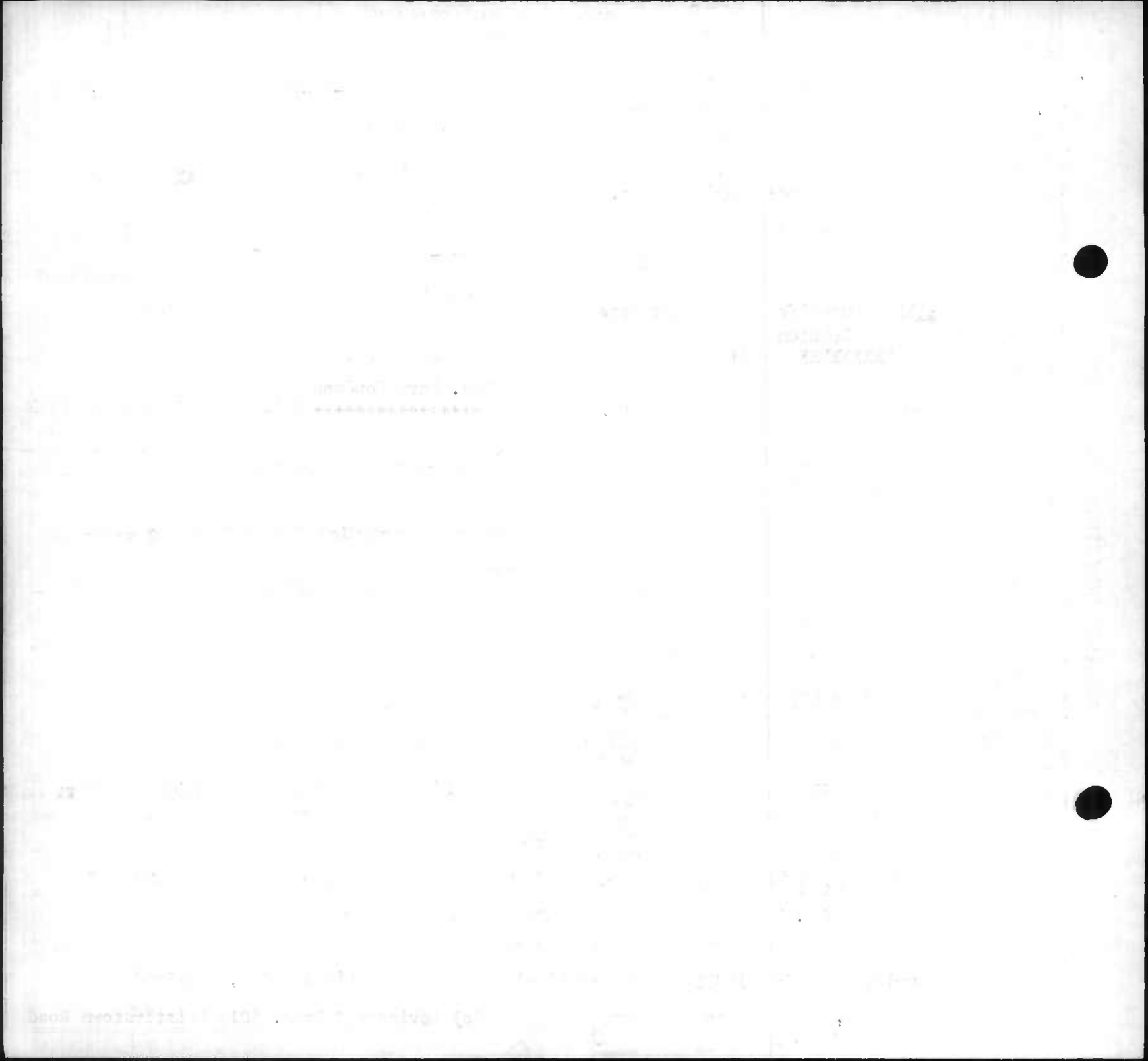
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 8863</u>	
S-240 71 8863		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Rebecca Sigel</u>		9-19-1971 5:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Levindale Hebrew Geriatric Center and Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1513</u>	
		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4108 Park Heights Ave</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <u>90</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Segal</u>		14. MOTHER'S MAIDEN NAME <u>Chai ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Sara Rice - 3212 Toney Road</u>		ADDRESS	
18. <u>410.9 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:	
(C) <u>Decubitus ulcer</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (u) (this hospital) attended the deceased from <u>9-27-1961</u> to <u>9-19-1971</u> that (u) (we) last saw the deceased alive on <u>9-19-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Soon Chul Hong</u>		23B. DATE SIGNED <u>9-19-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Soon Chul Hong</u>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION (City, town, or county) (State) <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

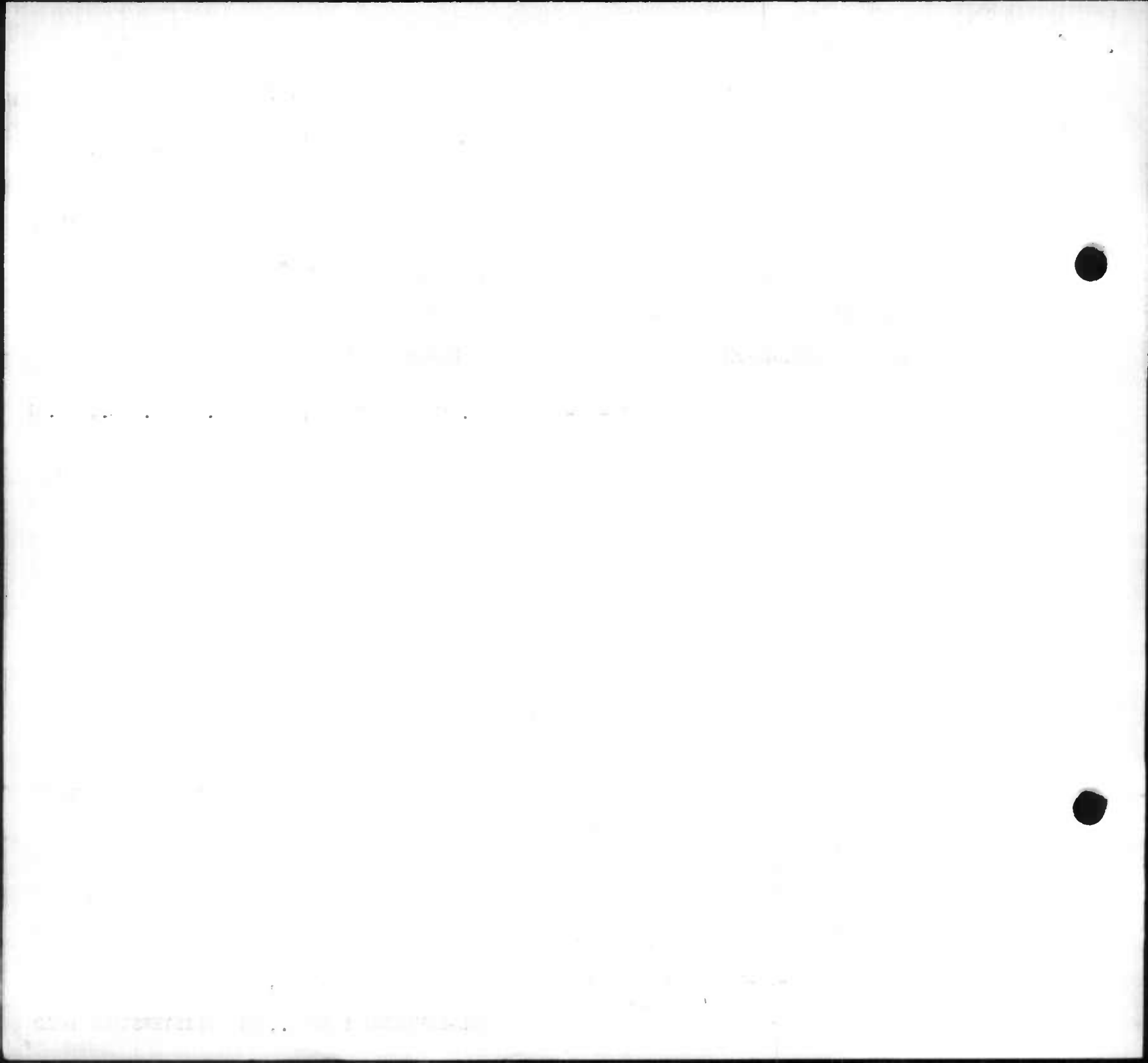
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8864</u>	
BIRTH NO. <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">A-524</div> <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">71 8864</div>		1. NAME OF DECEASED (Type or Print) <u>Celia Ansell</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">37</div> <u>Mercy Hospital, Inc.</u>		2. DATE AND HOUR OF DEATH <u>9-18-71</u> <u>8:15 PM.</u> 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3635 Glengyle Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-89</u>		9. AGE (In years last birthday) <u>82</u> If Under 1 Yr. Months: <u> </u> Days: <u> </u> If Under 24 Hrs. Hours: <u> </u> Min: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Zebulon</u> <u>Merritt Hurwitz</u>			
14. MOTHER'S MAIDEN NAME <u>Mollie Levy</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. Mary Goodman</u> <u>Hospital Records</u>			
18. CAUSE OF DEATH <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Several old myocardial infarctions</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>2 weeks</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>9/12</u> <u>19 71</u> to <u>9/18</u> <u>19 71</u> that (2) last saw the deceased alive on <u>9/18</u> <u>19 71</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Lee</u>				23B. DATE SIGNED <u>9/18/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Lee</u>				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>SEPT 19/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Har Sinai</u>	
24D. LOCATION (City, town, or county) (State) <u>Owings Mills, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Seal Levinson & Bros. 6010 Reisterstown Road</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-532 71 8865		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8865	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SANDERKOFF, SARAH.		9/17/71 5:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE			A. STATE MD. BALTO		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
42			E. STREET AND NUMBER 7015 PARK HEIGHTS AVE #15		
5. SEX FEMALE	6. RACE CAUCASIA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1889	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BERNARD KAHANOWITZ			14. MOTHER'S MAIDEN NAME SHANIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-66-8342	17. INFORMANT MRS. SYLVIA SILBER, 7015 PK. HGHTS. AVE., APT. B1		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 DAYS
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/13/71 to 9/17/71 that (I) (we) last saw the deceased alive on 9/17/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.			23B. DATE SIGNED 9/17/71		23C. PHYSICIAN'S NAME (Type) DAVID GLASER, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9-19-71		24C. NAME of CEMETERY or CREMATORY PETACH TIKVAH
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971			25B. NAME OF REGISTRAR Robert E. Silber, M.D.		25C. FUNERAL DIRECTOR (Sole) LEVINSON & BROS., 6010 REISTERSTOWN ROAD



G-600

71

8866

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

8866

REG. NO.

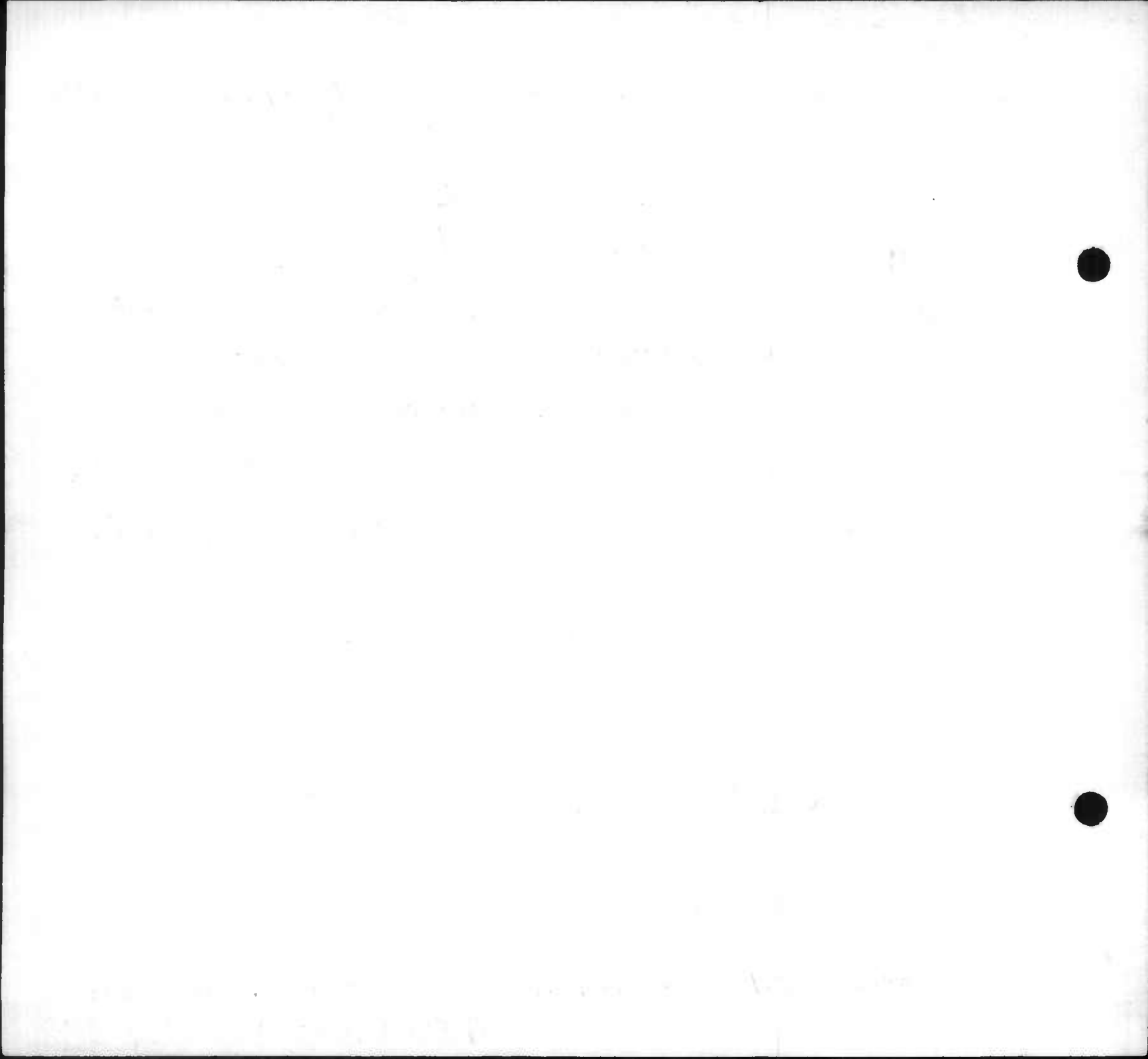
BIRTH NO.

1. NAME OF DECEASED (Type or Print) A. Roberta Gray		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 118 E. 33rd Street Apt. D.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 16 71 3:38 A. M.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9/26/1887		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 83		E. STREET AND NUMBER 118 E. 33rd Street	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cashier		14B. KIND OF BUSINESS OR INDUSTRY ELECTRICAL	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Herbert Witz		ADDRESS Fidelity Bldg	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/18/71	
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		ADDRESS 8500 York Rd.	

FUNERAL DIRECTOR: IMPORTANT

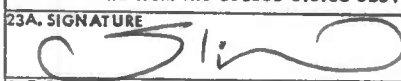
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8867	
BIRTH NO. J-52571 8867			
1. NAME OF DECEASED (Type or Print) CHARLES R JOHNSON		2. DATE AND HOUR OF DEATH 9/13/1971 2 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8. COUNTY BALTO 5390 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7048 HEATHFIELD RD	
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/07 9. AGE (in years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARCHITECT		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE H JOHNSON		14. MOTHER'S MAIDEN NAME SADIE MARKLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578 32 9333	17. INFORMANT SPOUSE (ELIZABETH) ADDRESS "SAME"
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC LYMPHATIC LEUKEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE RESPIRATORY FAILURE 60min ACUTE RENAL FAILURE 12hrs	
19A. DATE OF OPERATION 22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/11 19 71 to 9/13 19 71 and that (1) (we) last saw the deceased alive on 9/13 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William Stuart MD		23B. DATE SIGNED 9/13/71	
23C. PHYSICIAN'S NAME (Type) WILLIAM STUART MD		23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/16/71	24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	24D. LOCATION (City, town, or county) (State) Dogwood Rd. Woodlawn Cemt
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971	25B. NAME OF REGISTRAR [Signature]	25C. FUNERAL DIRECTOR ADDRESS 6500 YORK ROAD JOHNSON	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8868	
C-436 71 8868				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CALDER ISACETTA M.		2. DATE AND HOUR OF DEATH 9-15-71. TIME 2:10 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1102		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12-7-1886 9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stenographer Fed. Land Bk.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME William F. Calder			14. MOTHER'S MAIDEN NAME Addeline ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 210-28-7641A		17. INFORMANT Mrs. W. I. Norris 6900 York Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RENAL FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fr of hip			MEDICAL EXAMINER'S SIGNATURE		
19A. DATE OF OPERATION 9-1-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Hip		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ardleigh Nursing Home -2095 Rock Rose Ave.	
21D. TIME OF INJURY (APPROX.) 8 30 71 p.m.		21E. INJURY OCCURRED While At Work		21F. HOW DID INJURY OCCUR? Subject fell	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 9/16/71		23C. PHYSICIAN'S NAME (Type) HOUSE STAFF
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/18/71		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery
24D. LOCATION (City, town, or county) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		
25B. NAME OF REGISTRAR Mitchell			25C. FUNERAL DIRECTOR Wiedefeld Home 6500 York Rd.		

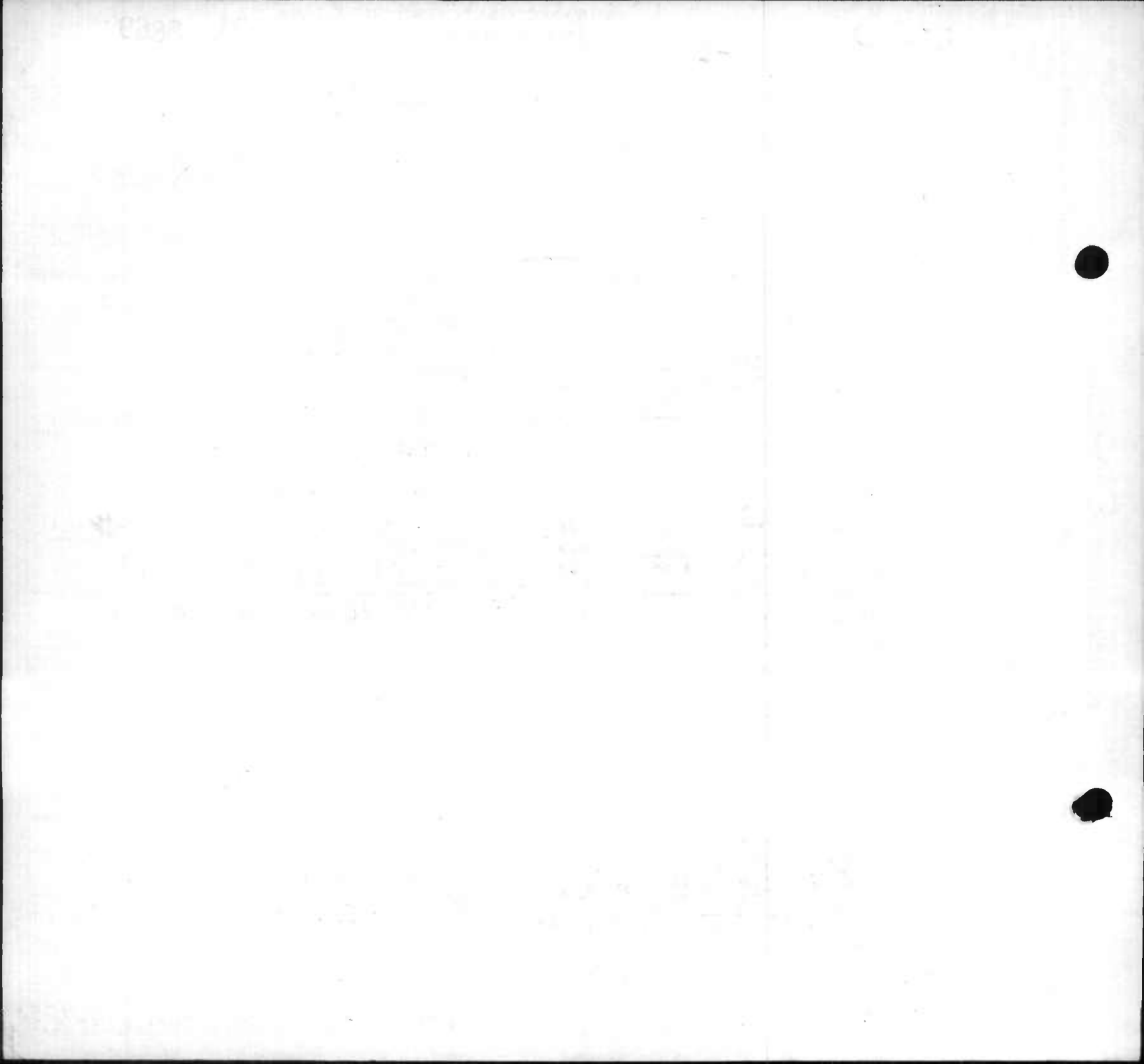
1518 N. Charles

Adm. 12/3/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8869	
P-360 71 8869		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Petry, Dorothy		2. DATE AND HOUR OF DEATH 9-19-71 5:31 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 So Balto Gen Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 219 E. Heath Street			
5. SEX Female	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED	8. DATE OF BIRTH 6-27-18	9. AGE (in years last birthday) 53	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Adam Klebe		14. MOTHER'S MAIDEN NAME Amelia Geisler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Family - same as #4	
18. 250.91		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METABOLIC ACIDOSIS ACUTE PULMONARY OEDEMA. HYPERTENSION. (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS (C) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 years. 13 years 1 year.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Notify medical examiner <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sep 19, 1971 to Sep 19, 1971 that (I) (we) last saw the deceased alive on Sep 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hargit Singh M.D.		23B. DATE SIGNED 9-19-71			
23C. PHYSICIAN'S NAME (Type) HARJIT SINGH M.D.		23D. ADDRESS 3001 S. HANOVER ST. BALTIMORE Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-71		24C. NAME OF CEMETERY OR CREMATORY Glen Burnie Com.	
24D. LOCATION (City, town, or county) (State) Glen Burnie AA Md					
25A. DATE RECEIVED BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR E. J. ...		25C. FUNERAL DIRECTOR ADDRESS McCluskey 430 E. Fort Ave. Balto 21230	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8870

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE J. BLAIR Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Sept. Day 17, Year 1971 Estimated <input type="checkbox"/>		3. DATE PRONOUNCED DEAD Month Sept. Day 17, Year 1971 Hour 6:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		6. SEX Male 7. RACE White B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3/11/1915		10. AGE (In years last birthday) 56		E. STREET AND NUMBER 616 Orpington Rd.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert J. Blair	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY M.T.A.		15. MOTHER'S MAIDEN NAME Annie F. Falter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		17. SOCIAL SECURITY NO. 216-10-3407		18. INFORMANT ADDRESS Catherine M. Blair 616 Orpington Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9/21/1971		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-18-71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/1971		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 5151 Balto. Nat'l. Pike		25E. DATE 9-18-71	

ACADEMIC RECORD

1

W-452

71

8871

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

8871

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BOBBY

R.

WILLIAMS

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

Sept. 17, 1971

7:45 P M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

Sept. 17, 1971

7:45 P M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Anne Arundel

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

July 14, 1936

10. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

7609 Marcy Drive

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hugh Leverne Williams

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Manager

14B. KIND OF BUSINESS OR INDUSTRY

Mechanical Cont.

15. MOTHER'S MAIDEN NAME

Dorothy Emerson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

243-50-3827

18. INFORMANT

ADDRESS

Dorothy Williams 7609 Marcy Dr.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of head
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

7609 Marcy Drive, Glen Burnie

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 9-17-71 about 5 P.m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-18-71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9-29-71

24C. NAME of CEMETERY or CREMATORY

Evergreen Memorial

24D. LOCATION

(City, town, or county)

(State)

Wilson North Carolina

25A. DATE REC'D BY HEALTH DEPT.

SEP 22 1971

25B. NAME OF REGISTRAR

Robert A. Pumphrey, M.D.

25C. FUNERAL DIRECTOR

Bethesda ADDRESS

Md.

Robert A. Pumphrey Funeral Homes, PA

ACADEMY

1887

1887

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 8872		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8872	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Elmore Johnson</u>		2. DATE AND HOUR OF DEATH <u>9/11/71</u> <u>1 P45A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>HOWARD</u> <u>6300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> <u>38</u>		C. CITY OR TOWN <u>JESUP</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>MD. HOUSE OF CORRECTION</u>		5. SEX <u>M</u>		6. RACE <u>N</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/2/23</u>		9. AGE (In years last birthday) <u>48</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Moses Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Rosetta Davis</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MISS MARY ANN JOHNSON</u> <u>Daughter</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u> <u>2 days</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Subacute Intestine</u> <u>YEARS</u>					
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> 19 <u>71</u> to <u>9/11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/11</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jeffrey Samuel MD</u>		23B. DATE SIGNED <u>9/11/71</u>		23C. PHYSICIAN'S NAME (Type) <u>JEFFREY SAMUELS MD</u>	
23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> <u>BALTIMORE MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-17-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Md. National Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Pr. Geo. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>	
25B. NAME OF REGISTRAR <u>Robert L. Snowden</u>		25C. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25D. ADDRESS <u>Rockville, Md.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8873
BIRTH NO. R-152 71 8873 71-15952				
1. NAME OF DECEASED (Type or Print) Baby Boy Robinson		2. DATE AND HOUR OF DEATH 9/19/71 12:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13011		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 125 N. Colvin St.		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/71	9. AGE (In years last birthday) 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Noreen Robinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR
22. I certify that (I) (this hospital) attended the deceased from 9/18/71 19 71 to 9/19 19 71 that (I) (we) last saw the deceased alive on 9/19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Robert E. Galt		23B. DATE SIGNED 9/20/71		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-21-71		24C. NAME of CEMETERY or CREMATORY
24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD

730 Wellington one
called Hospital.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8874		
BIRTH NO. S-415 71-15951 8874		CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Baby Girl Sullivan			2. DATE AND HOUR OF DEATH 9/19/71 12:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 37 </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital, Inc. </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Maryland </div> <div> B. COUNTY AA 5200 </div> </div>			
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/18/71			9. AGE (In years last birthday) 3 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Alton Sullivan			14. MOTHER'S MAIDEN NAME Catherine Sekulus			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Prematurity DUE TO, OR AS A CONSEQUENCE OF: (B) Placental Dysfunction DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) <div style="display: flex; justify-content: space-between;"> <div> 1 (Month) 1 (Day) 1 (Year) 1 (Hour) </div> <div> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> </div>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 9/18 19 71 to 9/19 19 71 that (I) (we) last saw the deceased alive on 9/19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE [Signature]				23B. DATE SIGNED 9/20/71		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-21-71		24C. NAME OF CEMETERY or CREMATOR		
24D. LOCATION (City, town, or county)		24E. LOCATION (State)				
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		
25D. ADDRESS						



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

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shared to
3204 Prohury St

C-640 71

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8876

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EDDIE ROGER CARROLL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1028 S. Streeper St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 1971 5:20 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Dec 18, 1943		10. AGE (In years last birthday) 27	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar Carroll		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 201	
15. MOTHER'S MAIDEN NAME Ada Mae		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 233-68-4246		18. INFORMANT Mrs Donna Carroll	
19. 395.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rheumatic heart disease - aortic stenosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-20-81	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-1971	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

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THE COMPANY

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1960-1961

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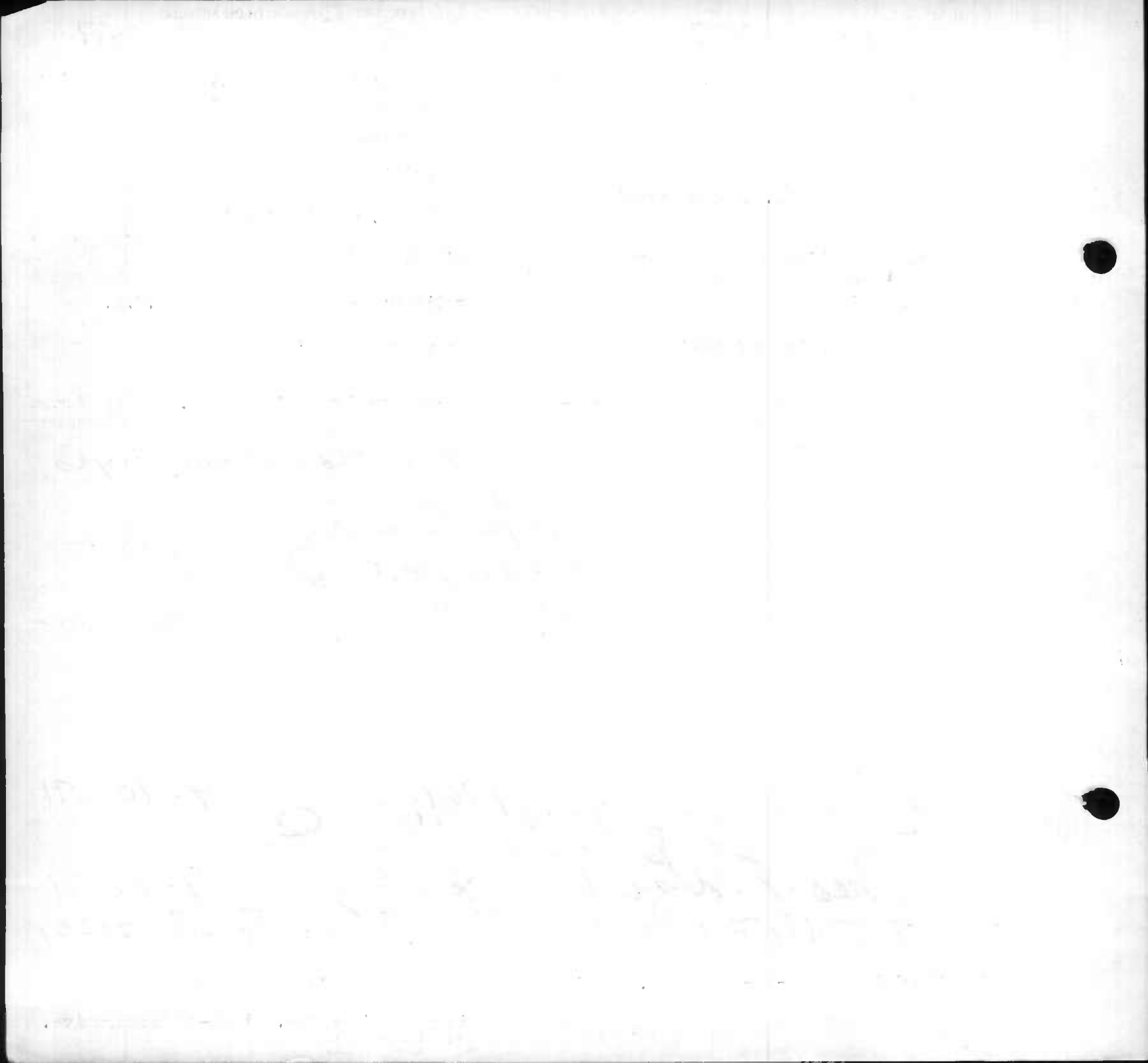
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8877</u>	
T-625 71 8877				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARTHA TROJANOWSKI		September 21, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 239 S. Castle Street			A. STATE Maryland B. COUNTY 201		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 239 S. Castle Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1896	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Kantorski		14. MOTHER'S MAIDEN NAME Mary Levandowski		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-30-9972		17. INFORMANT Bernard Trojanowski 239 S. Castle Street	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Circulatory Heart Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Gen ASCVD (C) Hypothyroidism & Pen An. 10+		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 1965 to 9-10-71, that (I) (we) last saw the deceased alive on 9-10-71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23A. SIGNATURE Thos. F. Dziwinski			23B. DATE SIGNED 9-22-71		
23C. PHYSICIAN'S NAME (Type) T. F. Dziwinski M.D.			23D. ADDRESS 429 S. Castle St 21231		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-1971		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



BIRTH NO.

1. NAME OF DECEASED (Type or Print) Gil Sanders		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 21 Year 71 Hour 6:15 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 21 Year 71 Hour 6:15 A. M.	
6. SEX Male		7. RACE Negro	
8. B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-22-18		10. AGE (In years last birthday) 52	
11. BIRTHPLACE (State or foreign country) York, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Misher Gore	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Odessa Skelton		ADDRESS 4205 Fern Hill Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Fatty Liver DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type): Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 9-21-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-26-71	
24C. NAME OF CEMETERY or CREMATORY Edward Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Lincolnton, N. C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

100-1-3-1

York, D. C.

Forest, D. C.

Forest, D. C.

Forest, D. C.

[Handwritten signature]

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York, D. C.

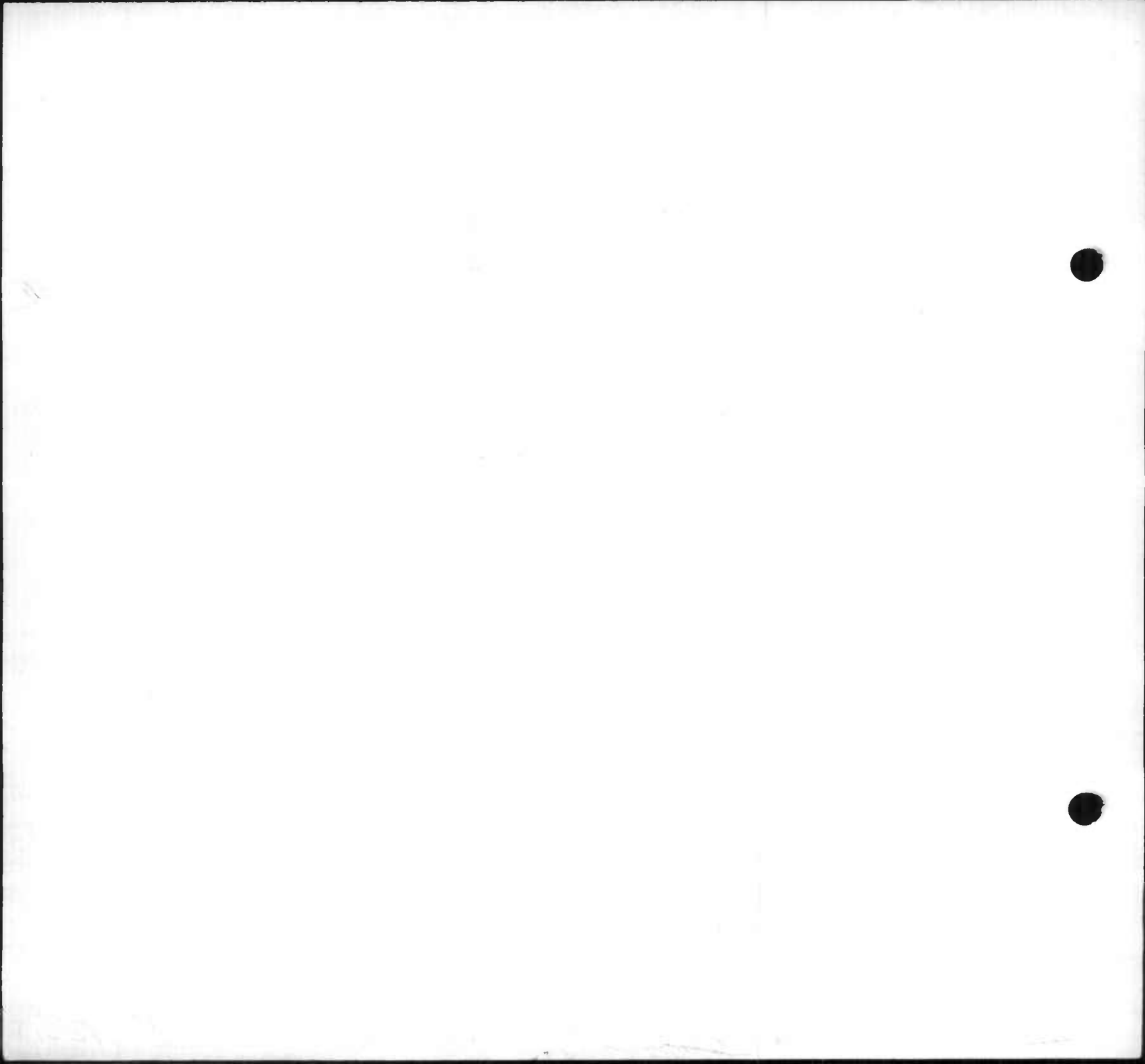
Forest, D. C.

Forest, D. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8879	
BIRTH NO. 71 8879		1. NAME OF DECEASED (Type or Print) FRANK MAJEWSKI			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MD. GENL HOSP.		2. DATE AND HOUR OF DEATH Sept. 19, 1971 12:02 A.M.			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY B		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/30/20		9. AGE (In years last birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCROLL SHEARS CO		10B. KIND OF BUSINESS OR INDUSTRY METAL		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME CHESTER MAJEWSKI		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ROBT. MAJEWSKI	
18. 4123 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael A. Silverman		23B. DATE SIGNED 9/19/71			
23C. PHYSICIAN'S NAME (Type) Michael A. Silverman		23D. ADDRESS MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/23/71		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.	
24D. LOCATION BALTIMORE MD.		24E. FUNERAL DIRECTOR FRANCIS L. KACZOROWSKI			
25A. DATE REC'D BY HEALTH DEPT. 9/23/71		25B. NAME OF REGISTRAR DR. E. J. JONES		25C. ADDRESS 2525 FLEET ST.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>743</u> 8880	
BIRTH NO. <u>71</u> 8880					
1. NAME OF DECEASED (Type or Print) <u>Sarah Valstrum WALSTRUM</u>		2. DATE AND HOUR OF DEATH <u>9/19/71</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View H.C.C.</u>		A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1213 Light St. Apt 2</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>F</u> 6. RACE <u>W.</u>		E. STREET AND NUMBER <u>2231 Lombard St.</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/6/1900</u> 9. AGE (In years last birthday) <u>71</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George - CHRIS SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Smith (Sarah)</u>		ADDRESS <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>230 54 622</u>		17. INFORMANT <u>MRS. SARAH SPIECH</u> ADDRESS <u>2511 GRAYMANOR RD.</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9/14/71</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <u>Arteriosclerotic CV disease</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>yes</u>	
ANTECEDENT CAUSES		(C) <u>arteriosclerotic generalized</u>		<u>yes</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> 19 <u>70</u> to <u>9/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/19</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>9/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MARCHAND MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9/22/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fabel, Jr.</u>		25C. FUNERAL DIRECTOR <u>RYMOND KACZOROWSKI</u> ADDRESS <u>2525 FLEET ST.</u>	

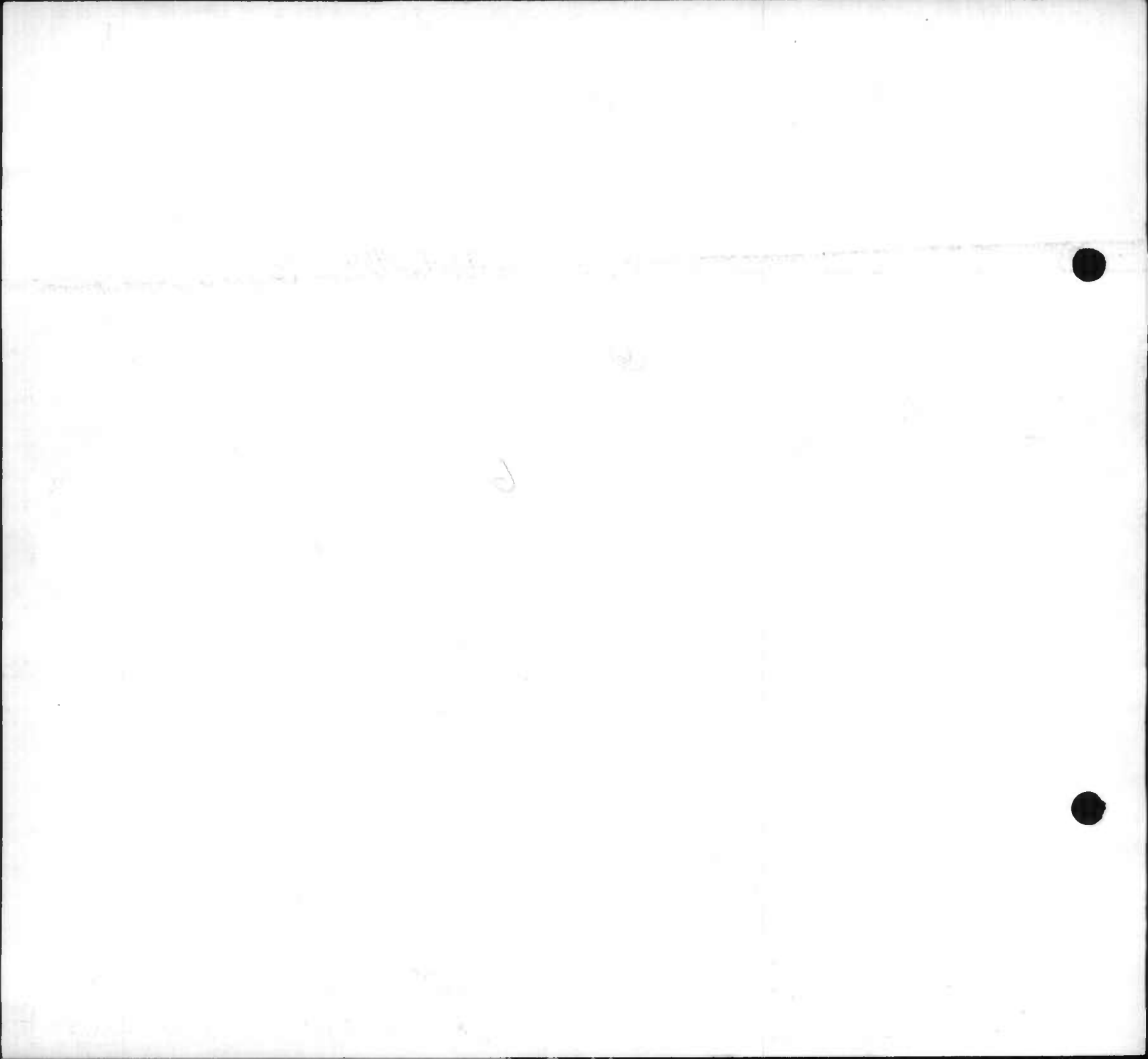
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FUNERAL DIRECTOR: IMPORTANT

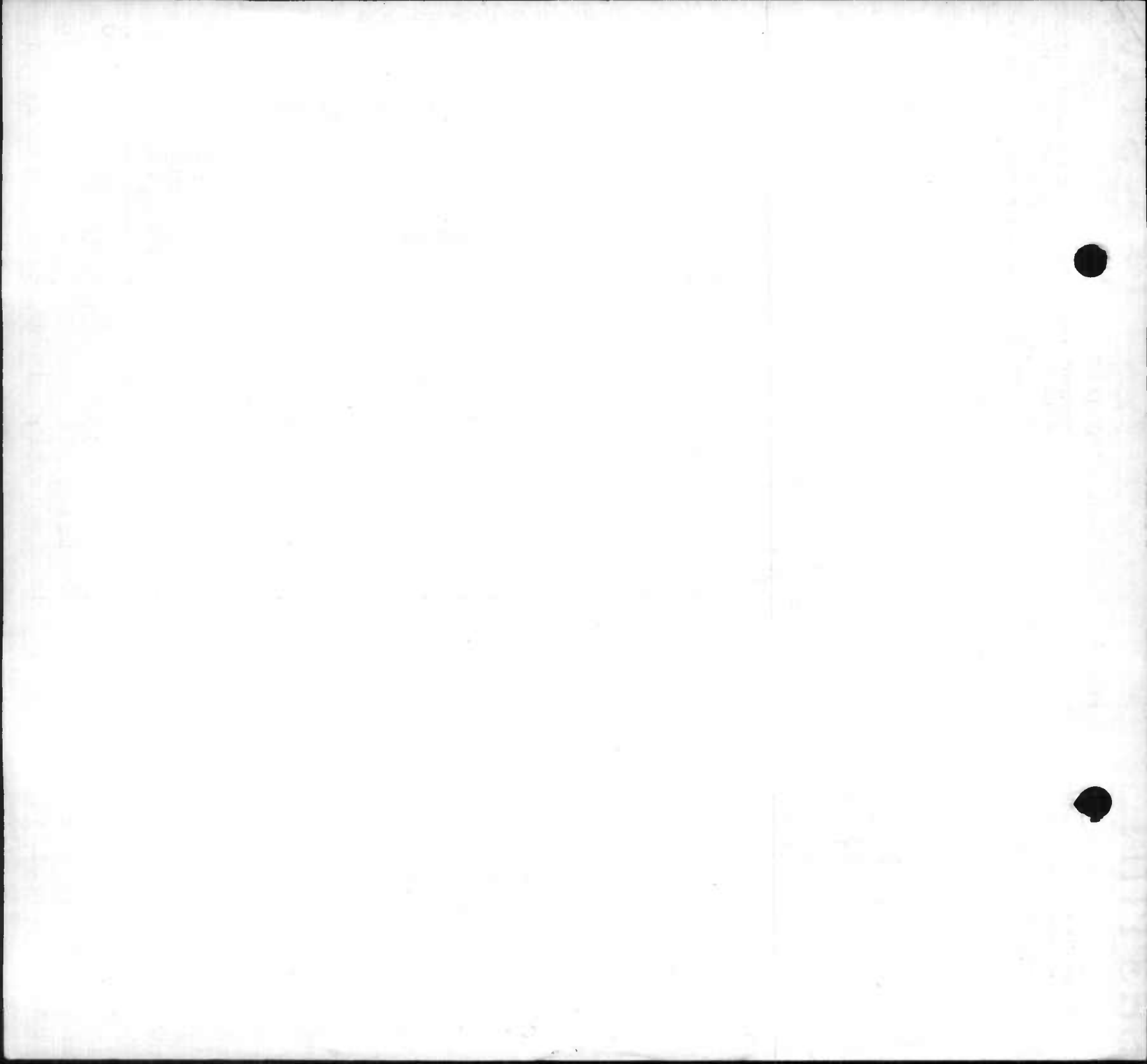
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 3221		K 5-12 8881		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8881	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) FRANCES R A D Z I E W S K I. J. (Komorowski)		2. DATE AND HOUR OF DEATH 9-17-1971. at 12 20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		M. COUNTY 103	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 634 S Montford Ave. #7				5. SEX Female		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-14-1900		9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? American				13. FATHER'S NAME Albert Rupinski			
14. MOTHER'S MAIDEN NAME Josephine Klopnowski				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 199 07 409				17. INFORMANT Mary Walsh 4721 Homedale Ave			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma Metastatic		?	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Intestinal obstruction		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 19-15-1971				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-1971 to 9-17-1971 that (I) (we) last saw the deceased alive on 9-17-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Benhami				23B. DATE SIGNED 9-17-1971			
23C. PHYSICIAN'S NAME (Type) ENAYATOLLAH BORHANI				23D. ADDRESS Church Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9/20/71		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
24D. LOCATION BALTIMORE MD.				25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR KACZOROWSKI 2525 Fleet St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

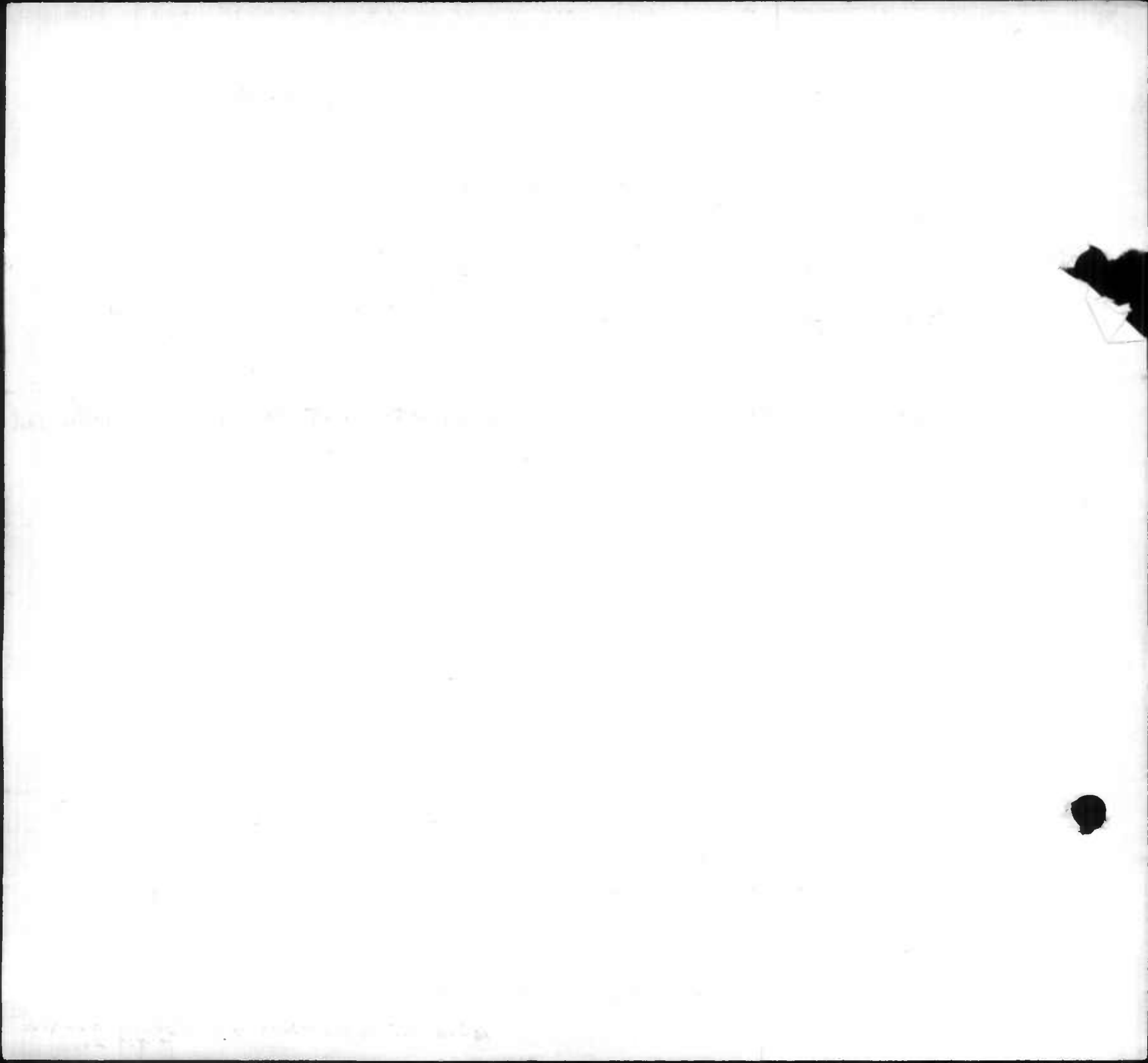
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8882</u>	
BIRTH NO. <u>71 8882</u>		1. NAME OF DECEASED (Type or Print) <u>OLIVER, SYLVESTER B. SR.</u>		2. DATE AND HOUR OF DEATH <u>9-19-1971 16³⁰ P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>2401</u>		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1409 Cooksire St.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City Jail</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvester Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Emma Maesh</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
		16. SOCIAL SECURITY NO. <u>705-09-642</u>		17. INFORMANT <u>Mary E. Oliver 1409 Cooksire St.</u>			
18. <u>441-91</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiopulmonary arrest.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aortic Aneurysm</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-14-1971</u> to <u>9-19-1971</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. Abosi</u>		23B. DATE SIGNED <u>9-19-1971</u>		23C. PHYSICIAN'S NAME (Type) <u>ALI ABOOSI</u>			
		23D. ADDRESS <u>8503 Glenn Michael Ln. BALTIMORE, MD 21133</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>STEVENS Funeral Home, Inc. 1501 EAST FORT AVENUE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8883	
BIRTH NO. 71 8883					
1. NAME OF DECEASED (Type or Print) GLORIA ANN STEWART		2. DATE AND HOUR OF DEATH 9:20 PM 9/16/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY AA			
		C. CITY OR TOWN ODONTON		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER RT. 1 Box 505			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/47	9. AGE (In years lost birthday) 24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME GEORGE MACK		14. MOTHER'S MAIDEN NAME HELEN BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Carl Stewart Rt. 1 Box 505 Odenton, Md	
18. 430-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RUPTURED BERRY ANEURYSM		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). SYSTEMIC LUPUS ERYTHEMATOSIS					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/14 19 71 to 9/16 19 71 that (I) (we) last saw the deceased alive on 9/16 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey Samuel MD		23B. DATE SIGNED 9/16/71		23C. PHYSICIAN'S NAME (Type) JEFFREY SAMUELS MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) 9-22-71		24B. DATE 9-22-71		24C. NAME OF CEMETERY OR CREMATORY Wilson Mem. Ch. Cem	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR MSD White & Sons 4925 Penn Ave NE Wash DC	
24D. LOCATION (City, town, or county) (State) Gambrells MD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8884	
BIRTH NO. 71 8884		1. NAME OF DECEASED (Type or Print) <u>Xavier Garner, Jr.</u>		2. DATE AND HOUR OF DEATH <u>9-18-71</u> <u>3:00</u> <u>4</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Charles</u> <u>5800</u>			
		C. CITY OR TOWN <u>La Plata</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		E. STREET AND NUMBER <u>Star Rte. #3</u>		<u>21646</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-14</u>		9. AGE (in years last birthday) <u>57</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Xavier W. Garner, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Mary R. Murphy</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-36-6332</u>		17. INFORMANT <u>Adelaide G. Garner-Wife, La Plata, Md.</u>		
18. <u>573.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>hepatic failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>hepatic failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> 19 <u>71</u> to <u>9-18</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arnold G. Alexander MD</u>				23B. DATE SIGNED <u>9/19/1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u>				23D. ADDRESS <u>MGH Linden Ave Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/21/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Rest Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>La Plata, Charles, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, MD</u>		25C. FUNERAL DIRECTOR <u>Archant Funeral Home Inc.</u>		ADDRESS <u>La Plata, Md.</u>	

10/10/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 71 8885

BIRTH NO. 71 8885

1. NAME OF DECEASED
(Type or Print)

Baublitz, Leon G.

2. DATE AND HOUR OF DEATH

9/19/71 3:20 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33 THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 212054. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

136 N. BELNORD AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

24 06-06-25x

9. AGE (In years
last birthday)

46x

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.

47

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Md. Clark Lift

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN BAUBLITZ

14. MOTHER'S MAIDEN NAME

IDA COMPTON Lambert

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW2

16. SOCIAL
SECURITY NO.

220-18-9567

17. INFORMANT

Mrs. Madeline O. Baublitz 136 N. Belnord Ave.

ADDRESS

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Artery

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Severe ASCVD

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH3 in past
8 months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 21 19 71 to Sept. 19 19 71
that (I) (we) lost saw the deceased alive on Sept. 19 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John A. Nesbitt, MD

MD
DEGREEAttending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9-19-71

23C. PHYSICIAN'S
NAME (Type)

JOHN A. NESBITT, 3RD

M.D.
DEGREE

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

601 N. BROADWAY

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/22/71

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 22 1971

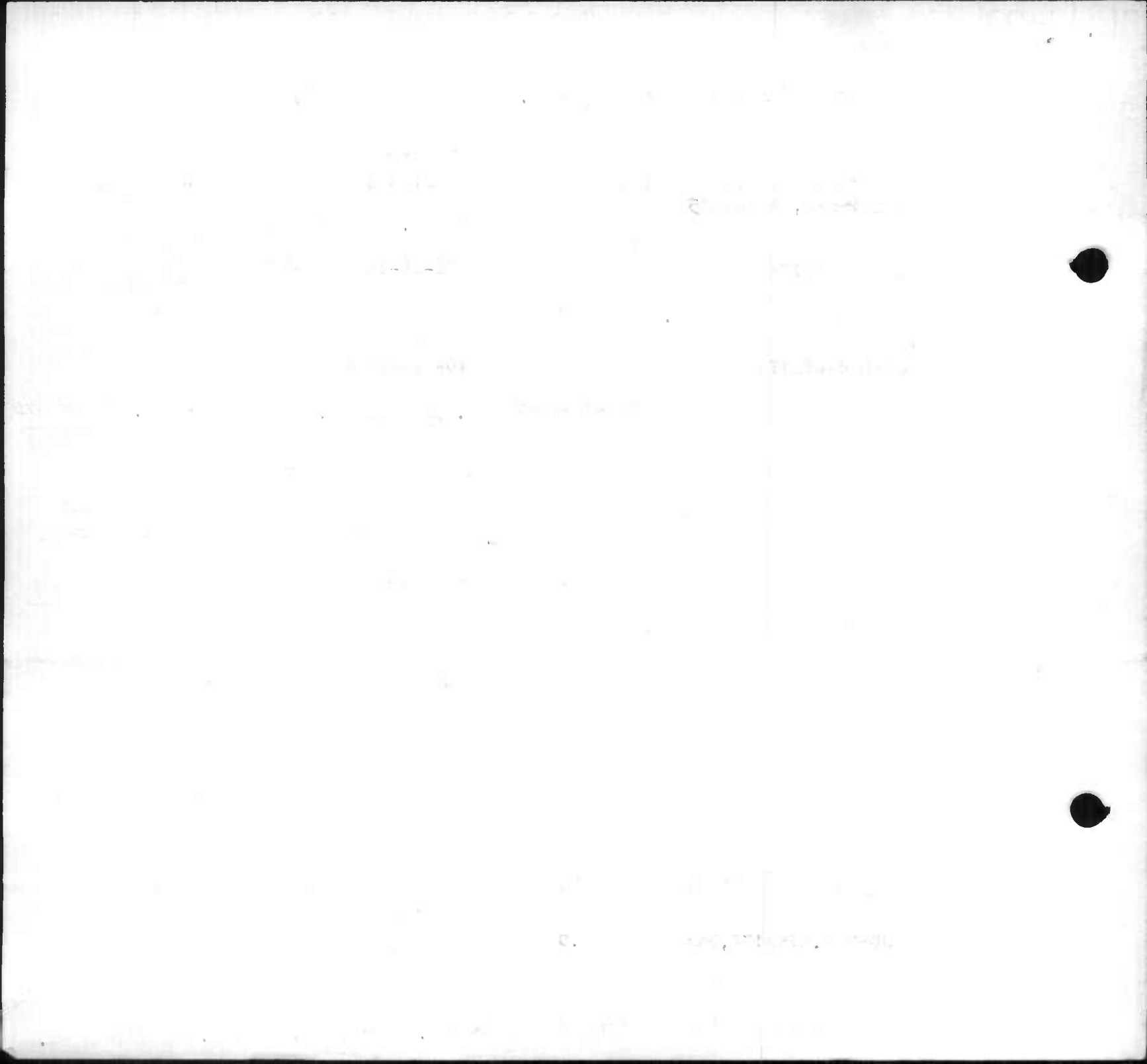
25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St.

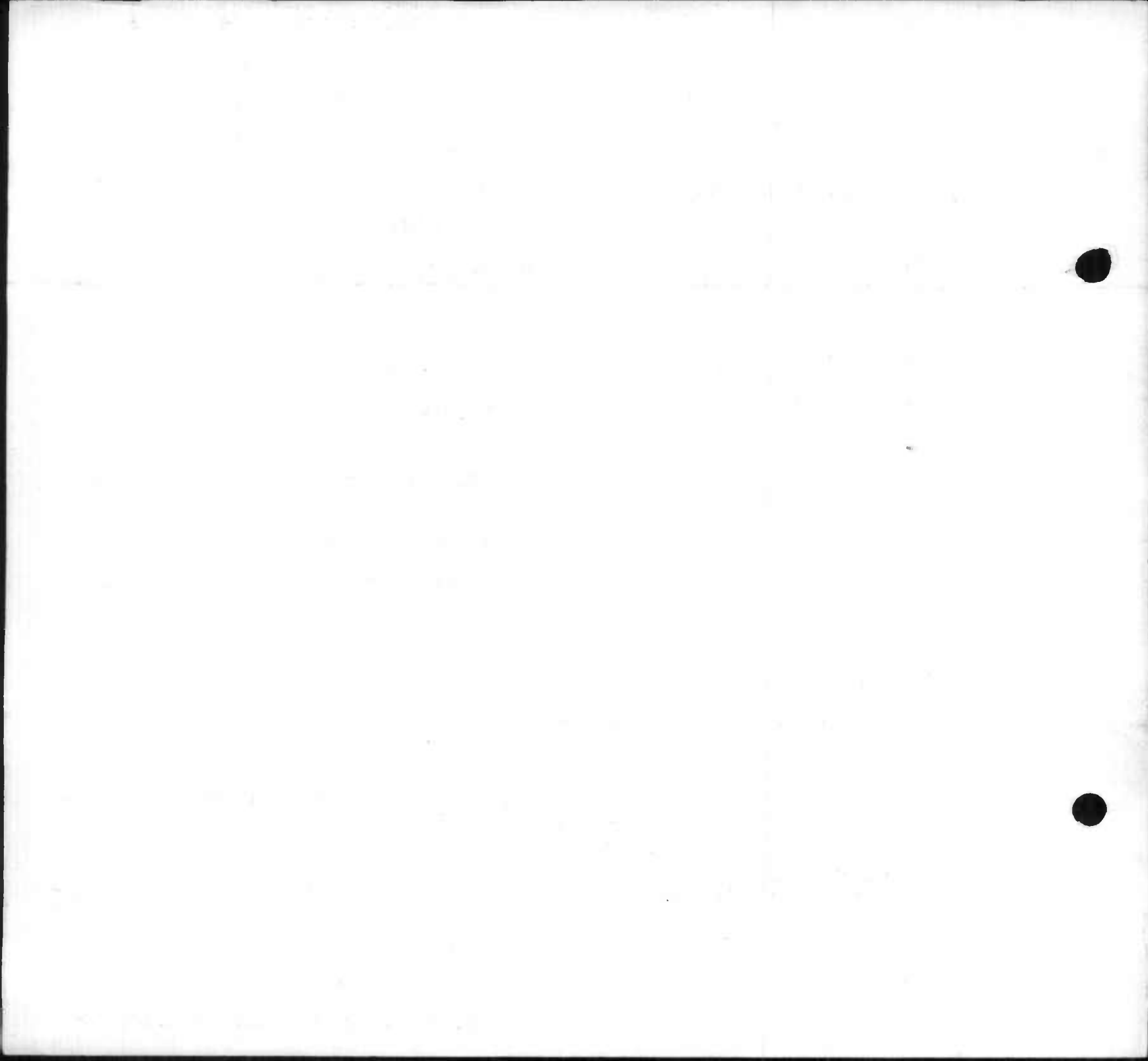
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 91 8886	
CERTIFICATE OF DEATH					
BIRTH NO. 71 8886		1. NAME OF DECEASED (Type or Print) PERRY MEYER			
2. DATE AND HOUR OF DEATH		Sept. 18, 1971 1:52 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
UNIV. OF MD HOSP 38		MD Dorchester		5900	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
4-9-20		51		USA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
-		-		AUGUST MEYER	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
BESSIE		-		-	
17. INFORMANT		ADDRESS			
Charles David Meyer Cambridge MD		-			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Renal failure 2 days			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hepatic Disease - cirrhosis years			
		(C) Alcoholism years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9-5-71		PORTAL HYPERTENSION		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>				NO	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 1, 1971 to Sept 18, 1971 that (I) (we) last saw the deceased alive on Sept 18, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Peter W. Beall, MD		Sept. 18, 1971		PETER W. BEALL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Sept 21, 1971		Dorchester Memorial Prk Cambridge Dorchester MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR, ADDRESS	
SEP 22 1971		Robert E. Taylor, MD		McCombs Funeral Home Cambridge MD	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8887

BIRTH NO. 71 8887

1. NAME OF DECEASED (Type or Print) MARION YATES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4310 Wentworth Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 1971 6:50 p M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2802			
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 5-29-1915		10. AGE (in years last birthday) 56	E. STREET AND NUMBER 4310 Wentworth Rd.
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Edmond Yates
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		14B. KIND OF BUSINESS OR INDUSTRY Sparrows Point	15. MOTHER'S MAIDEN NAME Janie Herriot
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		17. SOCIAL SECURITY NO. 249-42-0705	18. INFORMANT Carrie T. Yates
19. 571.8 I		CAUSE OF DEATH Fatty metamorphosis of liver	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/20/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-24-1971	24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE	

21 MAY 1964

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 5/1/64

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

ACADEMY BOND

PAID 5/1/64

NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 5-552 71 8888 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8888	
BIRTH NO. [REDACTED]		1. NAME OF DECEASED (Type or Print) SIMMONS EDNA			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO HOSP		2. DATE AND HOUR OF DEATH 8/21/1971 18:35 PM 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1402			
5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/1933 9. AGE (In years last birthday) 39		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY MORGAN		14. MOTHER'S MAIDEN NAME ROSE		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS PEARL CLARK, STEPHENVILLE, MD	
18. 410.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr ago many years ago	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28/1970 to 9/21/1971 that (I) (we) last saw the deceased alive on 8/21/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mamela HL				23B. DATE SIGNED 9/21/71	
23C. PHYSICIAN'S NAME (Type) MANTULA HL				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/25/71		24C. NAME of CEMETERY or CREMATORY Mt Auburn C'metry	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Gager, Jr.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W north Ave	

1000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. [REDACTED]	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Florence Moseley</i>		2. DATE AND HOUR OF DEATH <i>9-19-71 10 45 P M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Dukeland NSG. Home</i> <i>1501 N DUKELAND ST.</i> <i>BALTO. MD. 21216</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1607</i> C. CITY OR TOWN <i>BAITmore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1501 N. DUKELAND ST.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-10-01</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Nursing Home</i>		11. BIRTHPLACE (State or foreign county) <i>Baltimore, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>John W Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-14-0010-T</i>		17. INFORMANT <i>Mrs Catherine Gray, 1473 Pacific St</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION <i>9-20-71</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <i>7-20-1966</i> to <i>9-19-1971</i> that (I) (we) last saw the deceased alive on <i>9-19-1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Percival C. Smith</i>		23B. DATE SIGNED <i>9-19-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Percival C. Smith, M.D.</i>	
23D. ADDRESS <i>4200 Edmondson Avenue</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>9/24/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 23 1971</i>		25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead 1206 W North Ave</i>	

~~REDACTED~~
Came to Dukeland N.H. from
Midtown N.H. Adm. to. Dukeland
7/20/66. Seems to have been
in some NH for at least 5 yrs.
CT

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) YOSHIO KAWABE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> September 21, 1971 3:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 21, 1971 4:05 P. M.	
6. SEX Male		7. RACE Oriental	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Tsu City, Mi Pref, Japan	
9. DATE OF BIRTH May 8, 1950		10. AGE (In years last birthday) 21	
11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? Japan	
13. FATHER'S NAME Yoshiaki Kawabe		14. MOTHER'S MAIDEN NAME	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		16. KIND OF BUSINESS OR INDUSTRY Shipping	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT Terminal Shipping Co.		ADDRESS 32 South Street	
19. E 838.1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Ship	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? docked at Pier #1, S. Clinton		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 9-21-71 3:30 P. M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject in hold of ship and 20 tons of cargo descended upon him	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9-23-71	
24C. NAME OF CEMETERY or CREMATORY Tokyo		24D. LOCATION (City, town, or county) (State) Japan	
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS 1050 York Road Towson, Maryland	

REDAKED BY FBI

FUNERAL DIRECTOR: IMPORTANT

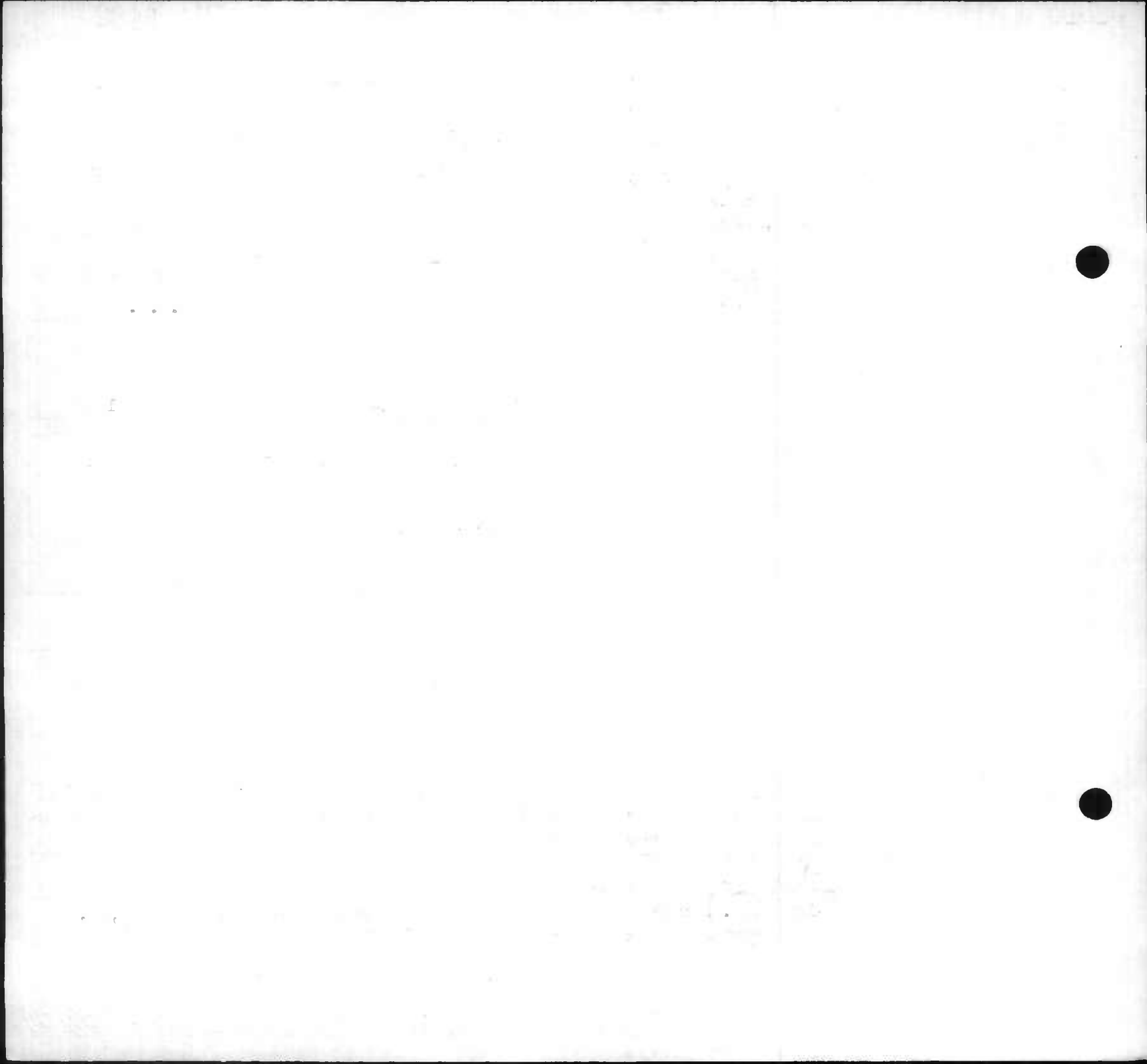
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8891		REG. NO.	
BIRTH NO.				71 8891		71 8891	
1. NAME OF DECEASED (Type or Print)				Howard Dysart Chisholm		2. DATE AND HOUR OF DEATH Sept. 19, 1971 10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		Mass. V 18	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
US Public Health Service Hospital 3100 Wyman Parkway				Danvers		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
M W				8. DATE OF BIRTH		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales training				EYEGLASSES		Mass.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Kenneth Chisholm				Florence Mc Gillvery RAY		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes USN 1943-1946				012-216-5252		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE		Days	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:		Bilateral lower lobe pneumonia	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Malignant lymphoma, poorly differentiated lymphocytic type		3 yrs.	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)				White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work			
22. I certify that (I) (this hospital) attended the deceased from Aug/ 13 19 71 to Sept. 19 19 71 that (I) (we) last saw the deceased alive on Sept. 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Robert E. Belliveau, M.D. (Surg)				9/20/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Robert E. Belliveau, Surg (R)				US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial/Removal 10-28 JET 71				10-28 JET 71		Mt. Wollaston Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 23 1971				Robert E. Belliveau, M.D.		Baltimore City Health Department	
25D. ADDRESS				25E. ADDRESS		25F. ADDRESS	
US PHS Hospital, Balto, Md.				US PHS Hospital, Balto, Md.		US PHS Hospital, Balto, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-256 71 8892</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 8892</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Irene Catherine Wiesner				9-18-1971		9.20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland		Baltimore	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
DUNDALK				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				F. STREET AND NUMBER			
3432 Louth Road 21222				3432 Louth Road 21222			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-14-1910	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Medical Secretary				MED. OFFICE		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harry Smith				Emma			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				213-84-6579		Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 1/2 hrs	
ANTECEDENT CAUSES				(B) Acute Myocardial Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from SEPT 18 19 71 to SEPT 18 19 71 that (1) (we) last saw the deceased alive on SEPT 18 9:15 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Michael L. Karpf M.D.				9/18/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MICHAEL L. KARPFF M.D.				4940 Eastern Avenue, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL				22 SEPT 71		PARKWOOD CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 23 1971				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
						VICTOR FUNERAL HOMES, DUNDALK, MD 21222	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

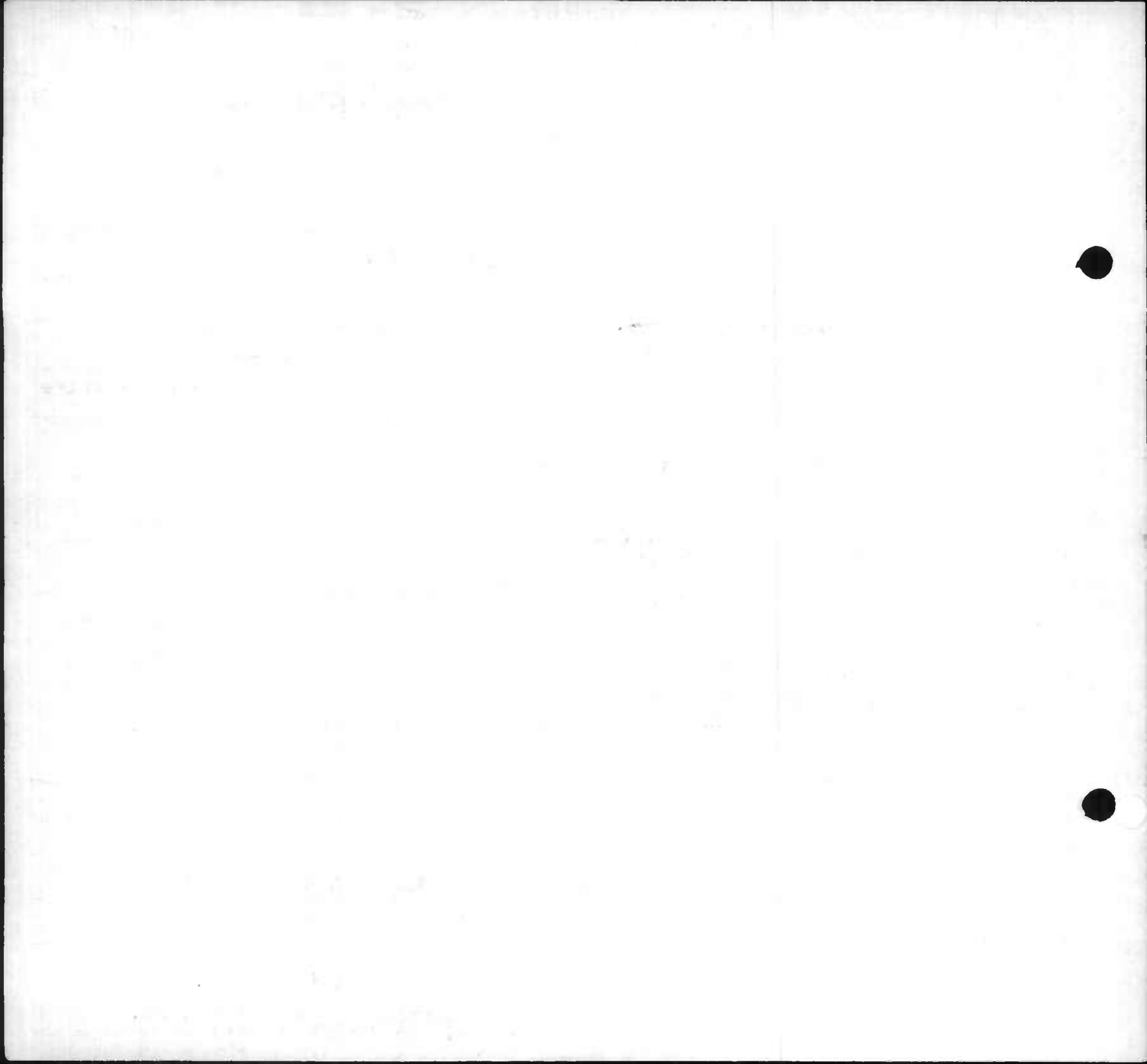
E-520 71 8893		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8893	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Edwin W. Ewing		2. DATE AND HOUR OF DEATH 9/19/71 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. CITY OR TOWN DUNDALK	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224		C. CITY OR TOWN DUNDALK		INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 11 Duinkerke Apts 21222 005		6. DATE OF BIRTH 3/14/24		9. AGE (In years last birthday) 47	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10B. KIND OF BUSINESS OR INDUSTRY Md. Port. Authority
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin Ewing	
14. MOTHER'S MAIDEN NAME Mary Insley		15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 216-16-3784	
17. INFORMANT BCH-Records Baltimore, Maryland 21224		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GI Bleeding Probable esophageal varices 2° to liver cirrhosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
19. DATE OF OPERATION 2		20. AUTOPSY? (Yes or No) YES		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
22. I certify that (I) (this hospital) attended the deceased from 9/8/71 to 9/9/71 and that (I) (we) last saw the deceased alive on 9/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE Malcolm Herwig M.D.		23B. DATE SIGNED 9-19-71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 21 Sept. 71		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) BALTO. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Paul E. J. Smith, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

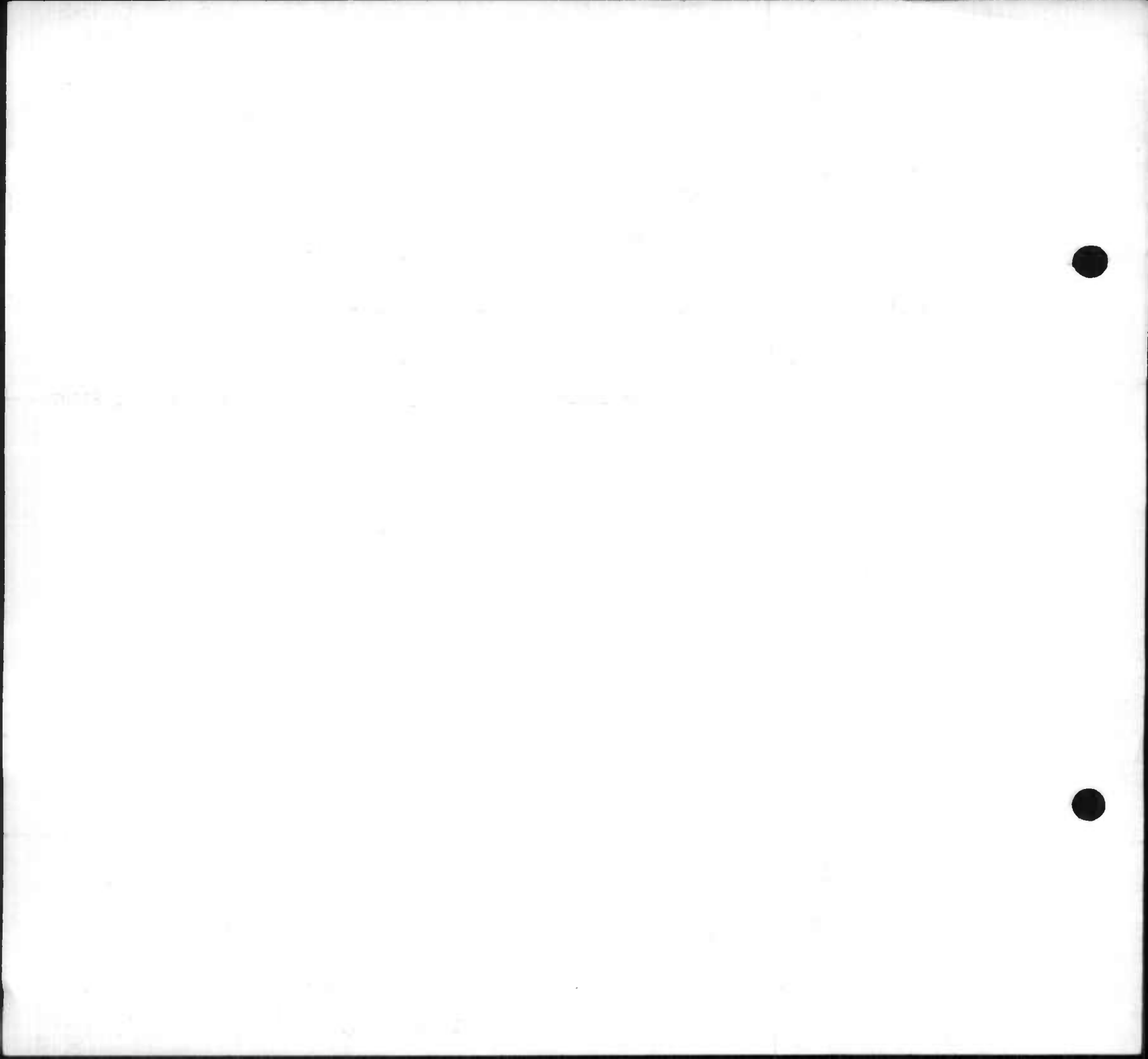
BIRTH NO. <u>A-240 71 8894</u>				CITY HEALTH DEPARTMENT BALTIMORE		REG. NO. <u>71 8894</u>	
1. NAME OF DECEASED (Type or Print) <u>HISLEY ELIZABETH</u>				2. DATE AND HOUR OF DEATH <u>9/18/71</u> <u>5-24 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME O HOSPITAL</u> <u>35 BALTIMORE</u>				A. STATE <u>MD</u>		B. COUNTY <u>101</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>712 S CURLEY ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-89</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
13. FATHER'S NAME <u>WIBANKA</u> <u>WIBANSKI VINCENT</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>22-18-9173</u>		17. INFORMANT <u>Wm. E. Hisley, son, 7551 Berkshire</u> <u>DR. MENDO CHM BALTO.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>1830</u> <u>RECTOVAGINAL FISTULA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Y.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>OVARIAN CARCINOMA</u> <u>CARCINOM OF CERVIX</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>OLD FX LEFT HIP IMPROV 8/31/71</u>							
19A. DATE OF OPERATION <u>9/17/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RECTOVAGINAL FISTULA</u>		20A. AUTOPSY? (Yes or No) <u>-</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		21C. WHERE DID INJURY OCCUR? <u>HOME</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>8/31/71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>FALL</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>9/29/71</u> 19 <u>71</u> to <u>9/18/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/18/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ashwin Mello</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/18/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ASHWIN MENDO</u>				23D. ADDRESS <u>CHURCH HOME O HOSP.</u> <u>BALTO. MD. 21231</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/22/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

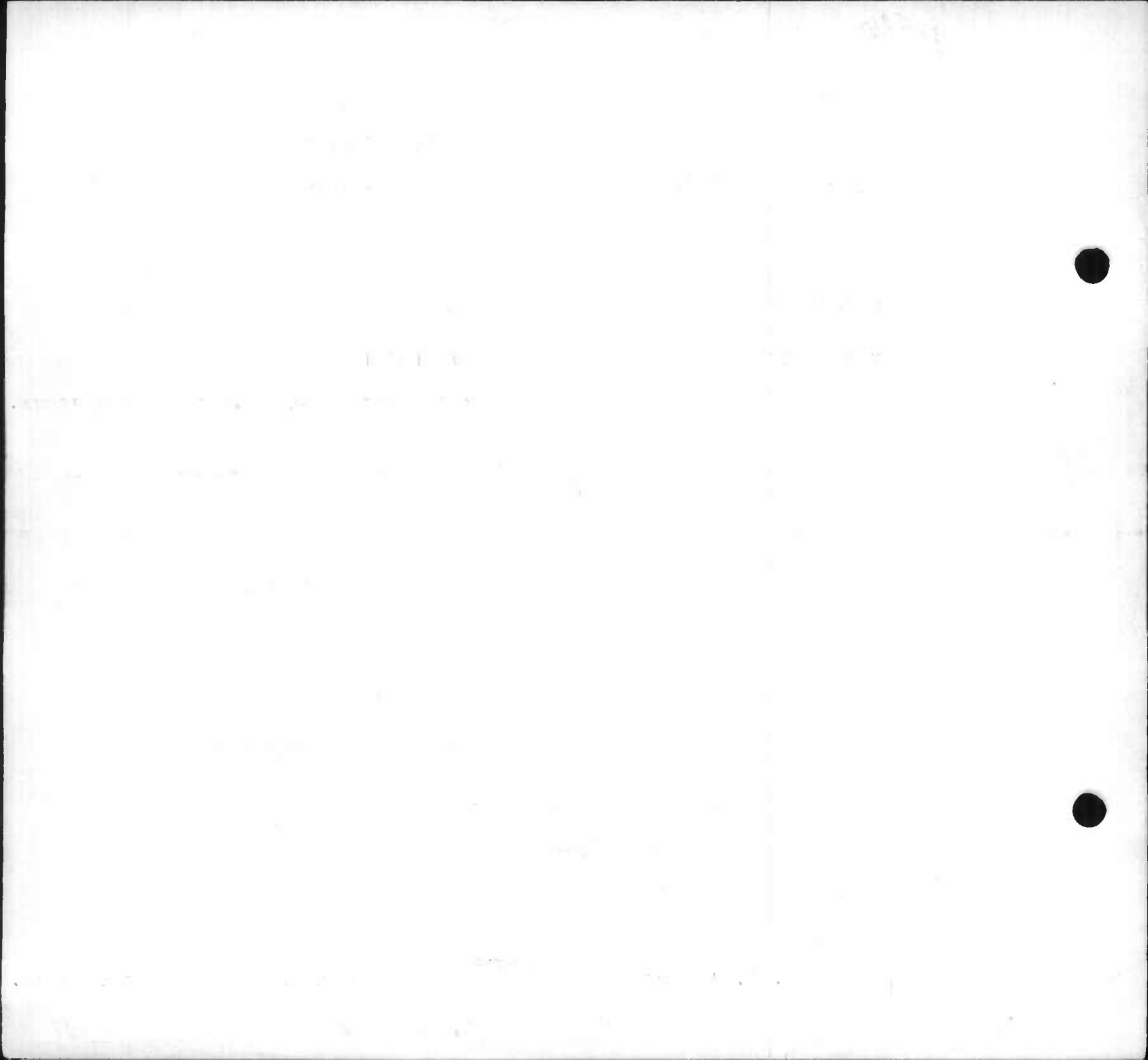
BALTIMORE CITY HEALTH DEPARTMENT				71 8895	
CERTIFICATE OF DEATH				REG. NO. 71 8895	
BIRTH NO. <u>B-210 71 8895</u>			1. NAME OF DECEASED (Type or Print) <u>MRS. AURE A. BUSHBY</u>		
2. DATE AND HOUR OF DEATH <u>Sept 20 / 71</u>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4402 SPRINGDALE ROAD BALTIMORE, MARYLAND 21207</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2802</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>4402 SPRINGDALE RD.</u>					
5. SEX <u>F.M.</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 06</u>	9. AGE (In years last birthday) <u>65</u>	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME MAKER</u>	11. BIRTHPLACE (State or foreign country) <u>PLEASANTVILLE-N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>FREDERICK F. PARSELLS</u>			14. MOTHER'S MAIDEN NAME <u>ALICE F. SNELL</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-28-4460</u>	17. INFORMANT ADDRESS <u>JAMES H. BUSHBY 4402 Springdale Rd. 21207</u>		
18. <u>412.3 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Nathan E. Needle</u>			23B. DATE SIGNED <u>9/21/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. NATHAN E. NEEDLE M.D.</u>			23D. ADDRESS <u>6506 Park Hgts. Ave. Baltimore Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/23/71</u>		24C. NAME of CEMETERY or CREMATORY <u>WOODLAWN CEMETERY</u>	
24D. LOCATION <u>WOODLAWN, BALTIMORE CO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>		25B. NAME OF REGISTRAR <u>Valley M.D.</u>		25C. FUNERAL DIRECTOR <u>LORING BYERS</u>	
25D. ADDRESS <u>31280 LIBERTY ROAD RANDALLSTOWN MD. 21133</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

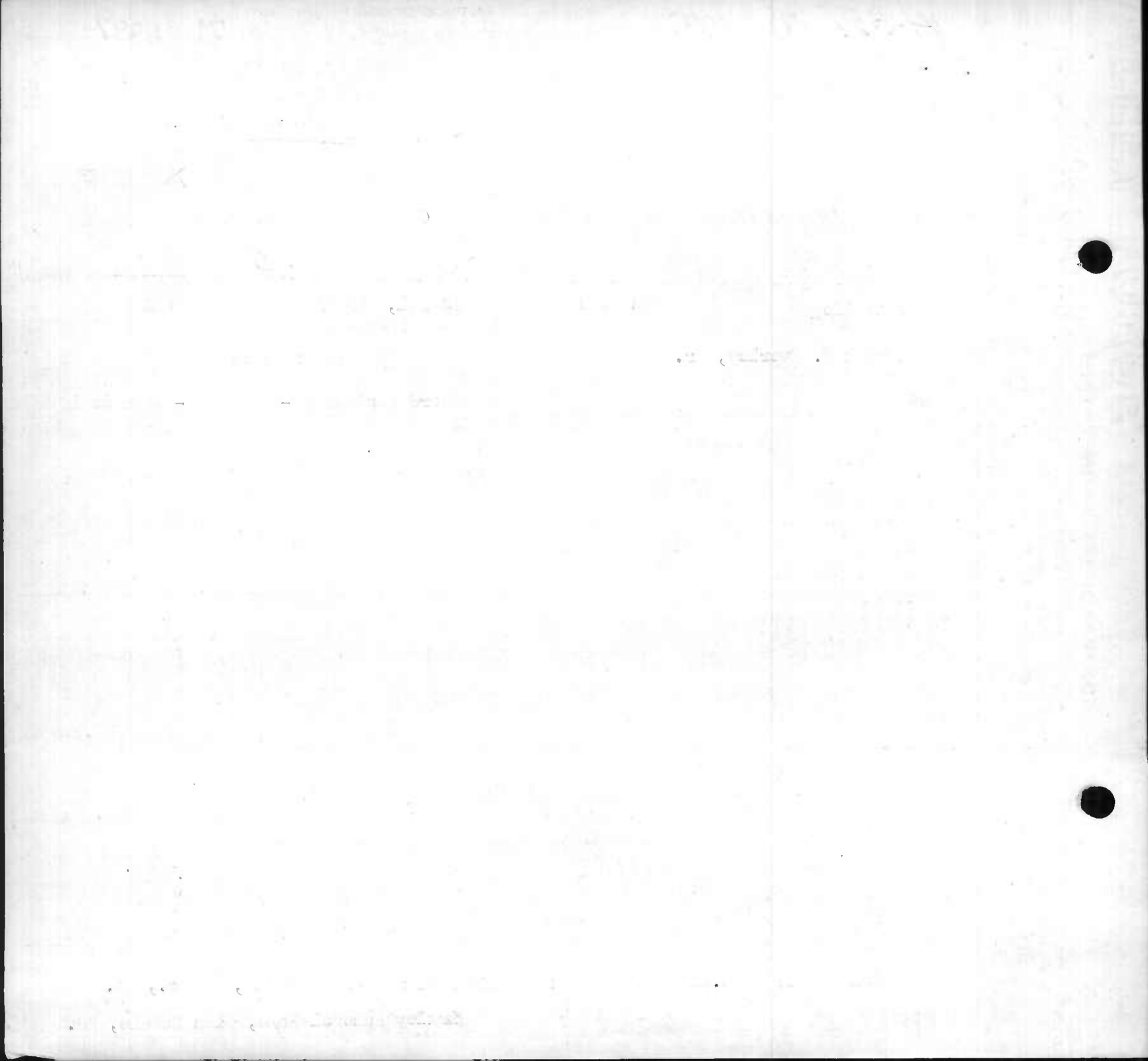
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				X REG. NO. <u>71 8896</u>	
<p>M-620 71 8896</p> <p>BIRTH NO. <u>Washington County</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>ANDREA MORSE</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9/19/71</u> <u>12:45</u> P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33601 N BROADWAY</u></p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>PENNA</u> B. COUNTY <u>FULTON</u></p> <p>C. CITY OR TOWN <u>WARFORDSBURG</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <u>RT #1</u></p>		
<p>5. SEX <u>F</u> 6. RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>6/2/71</u> 9. AGE (in years last birthday) <u>3</u> <u>17</u></p> <p>If Under 1 Yr. Months: Days: Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>					
<p>13. FATHER'S NAME <u>ROY E MORSE</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>JANICE I HANN</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>		<p>17. INFORMANT <u>ROY E MORSE RURAL 2 WARFORDSBURG PENNA.</u></p>	
<p>18. <u>596.01</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: <u>45 MIN</u></p> <p>(B) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 DAYS</u></p> <p>(C) <u>VESICO INTESTINAL FISSURE</u> <u>BIRTH</u></p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>2/6/3/71</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OMPHALOCLE REPAIR</u></p>		<p>20A. AUTOPSY? (Yes or No) <u>YES</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>(If in Baltimore City, give exact location)</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR?</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <u>this hospital</u> attended the deceased from <u>6/2</u> 19 <u>71</u> to <u>9/19</u> 19 <u>71</u> that <u>(1) (see)</u> last saw the deceased alive on <u>9/19</u> 19 <u>71</u> and that in <u>(my)</u> <u>(see)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(1) (We)</u> <u>(see)</u> view the body after death.</p>					
<p>23A. SIGNATURE <u>Basil John Zitelli MD</u></p>				<p>23B. DATE SIGNED <u>9/19/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>BASIL JOHN ZITELLI MD</u></p>				<p>23D. ADDRESS <u>601 N. BROADWAY</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>9.22.71</u></p>		<p>24C. NAME OF CEMETERY or CREMATORIUM <u>CEDAR GROVE</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>RURAL WARFORDSBURG FULTON PA.</u></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>2220 E. 4th St. 0 0 0</u></p>		<p>25C. FUNERAL DIRECTOR <u>Harold P. Stone</u></p>	
<p>ADDRESS</p>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

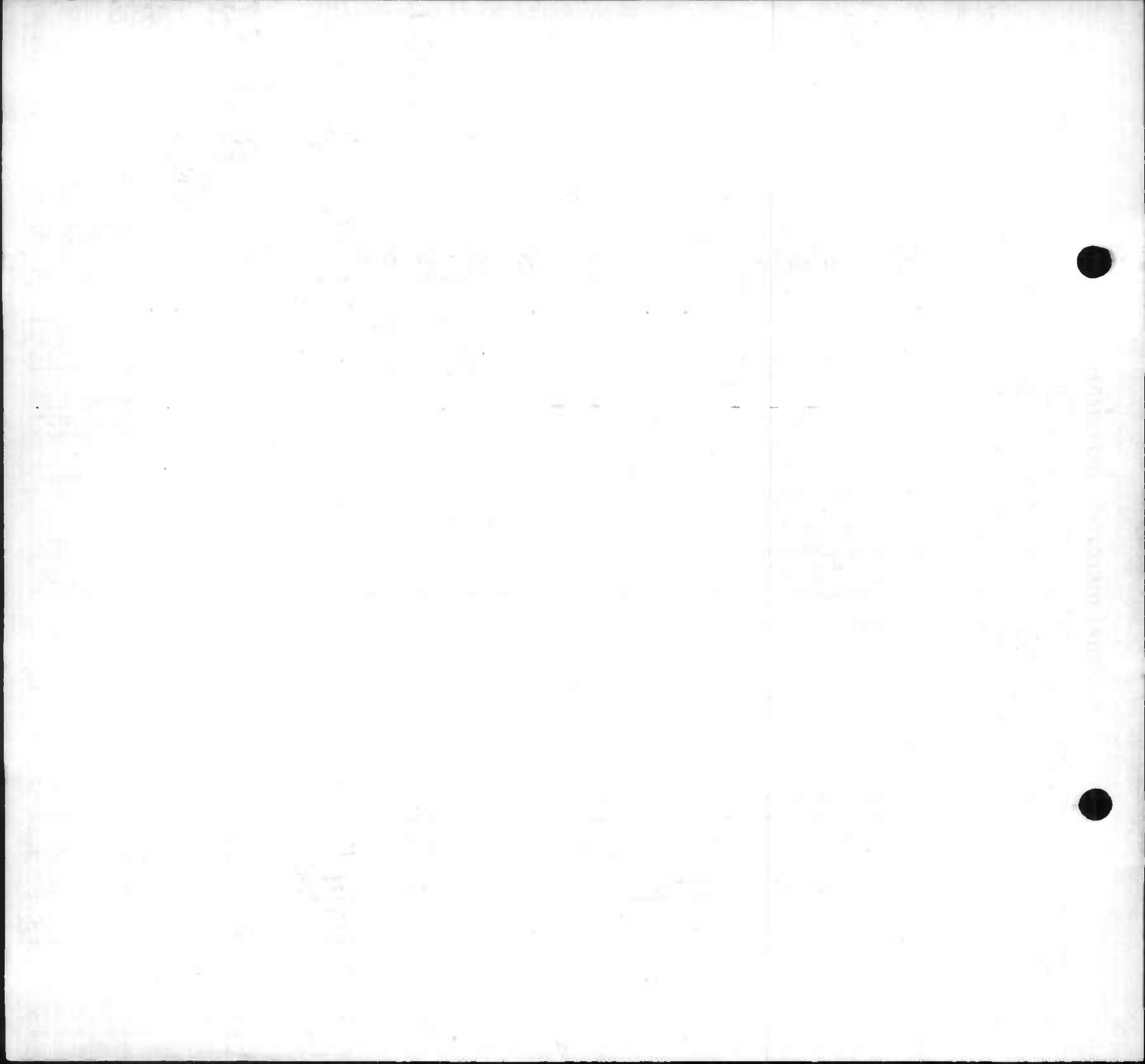
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8897	
H-364 71 8897					
CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) BETTY HEATHERLY			2. DATE AND HOUR OF DEATH 9/20/71 4:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 45 GOOD SAMARITAN HOSPITAL			A. STATE MD B. COUNTY ANN E. ARNO C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1700 Morning Rd.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/25	9. AGE (In years last birthday) 45	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Laurel, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank M. Everley, Sr.		14. MOTHER'S MAIDEN NAME Leona Howard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Edward Heatherly - Husband - same as 4.	
18. 157.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disseminated pancreas Ca		3 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/17 19 71 to 9/20/71 19 71 , that (I) (we) last saw the deceased alive on 9/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. GREENE MD				23B. DATE SIGNED 9/20/71	
23C. PHYSICIAN'S NAME (Type) A. GREENE MD				23D. ADDRESS Good Samaritan Hosp, Balt, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 23 Sept. 71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR 000000	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8898
P-6301 8898				REG. NO.
BIRTH NO.				71 8898
1. NAME OF DECEASED Type or Print PARDUE, WILSON		2. DATE AND HOUR OF DEATH 6:25 PM 9/20/71 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE # 21211 1307		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 828 W 36th St.		
5. SEX M	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-21-04	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY C. M. Kemp Co.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lee A. Pardue		
14. MOTHER'S MAIDEN NAME Maggie Keyes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-09-8952		17. INFORMANT Mrs. Leanna Spinks ADDRESS 7208 1/2 Harford Rd.		
18. 195.01 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspirating Pneumonia				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Abdominal Carcinomatosis with obstruction				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 04 mos. ago		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Carcinomatosis		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from September 20, 1971 to Sept 20, 1971 that (I) (we) last saw the deceased alive on Sept. 20, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED Sept. 20, 1971
23C. PHYSICIAN'S NAME (Type) RONALDO SANTOS CARNEIRO DEGREE		23D. ADDRESS 33rd & Calvert Sts Baltimore-Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/24/71	24C. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery (Hampton)		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-40071 8899		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 8899	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BALL, HERSHAL ALLEN		9-21-71 4:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
N. CHARLES GEN. Hospital				Maryland BALTO 5300	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Catonsville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
Forest Haven Nursing Home					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
M	W			11-24-03	67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Electrician		General		OHIO Ky	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
? Bud Ball				? Mary Shelton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		403-05-8528		Hospital Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Pneumonia					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				A SCUD & Cardiac failure.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-14-71 19 to 9-21-71 19 that (I) (we) last saw the deceased alive on 9-21-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				9-21-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Daniel Wilkerson - MD				NCGH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-24-71		Good Shepherd	
				Ellicott City Md.	
25A. DATE RECD. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 23 1971		Valerie E. [unclear]		H. [unclear] Slack	

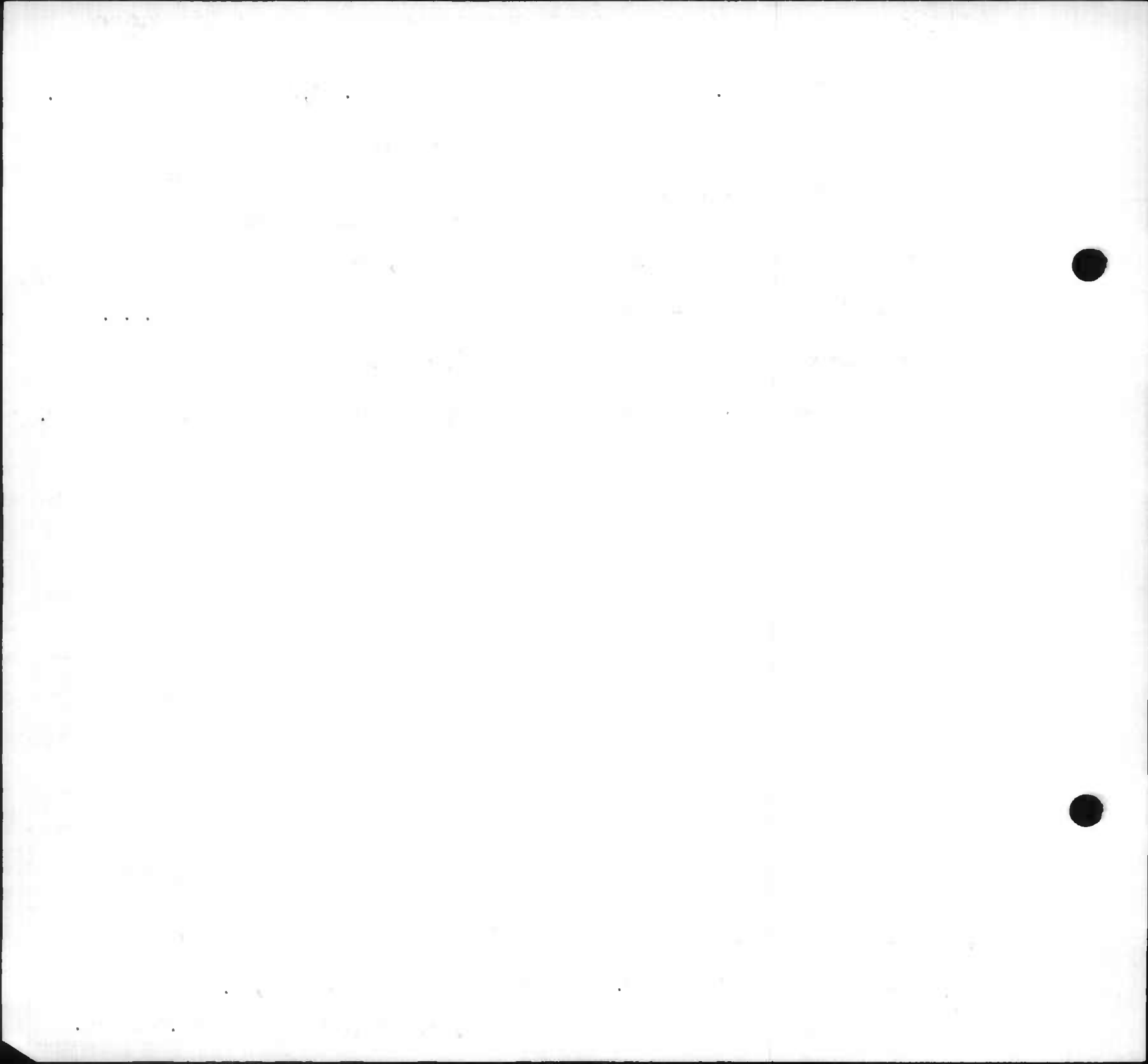
Adm. 12/2/70 to N.H.

unable to obtain prev. Add.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

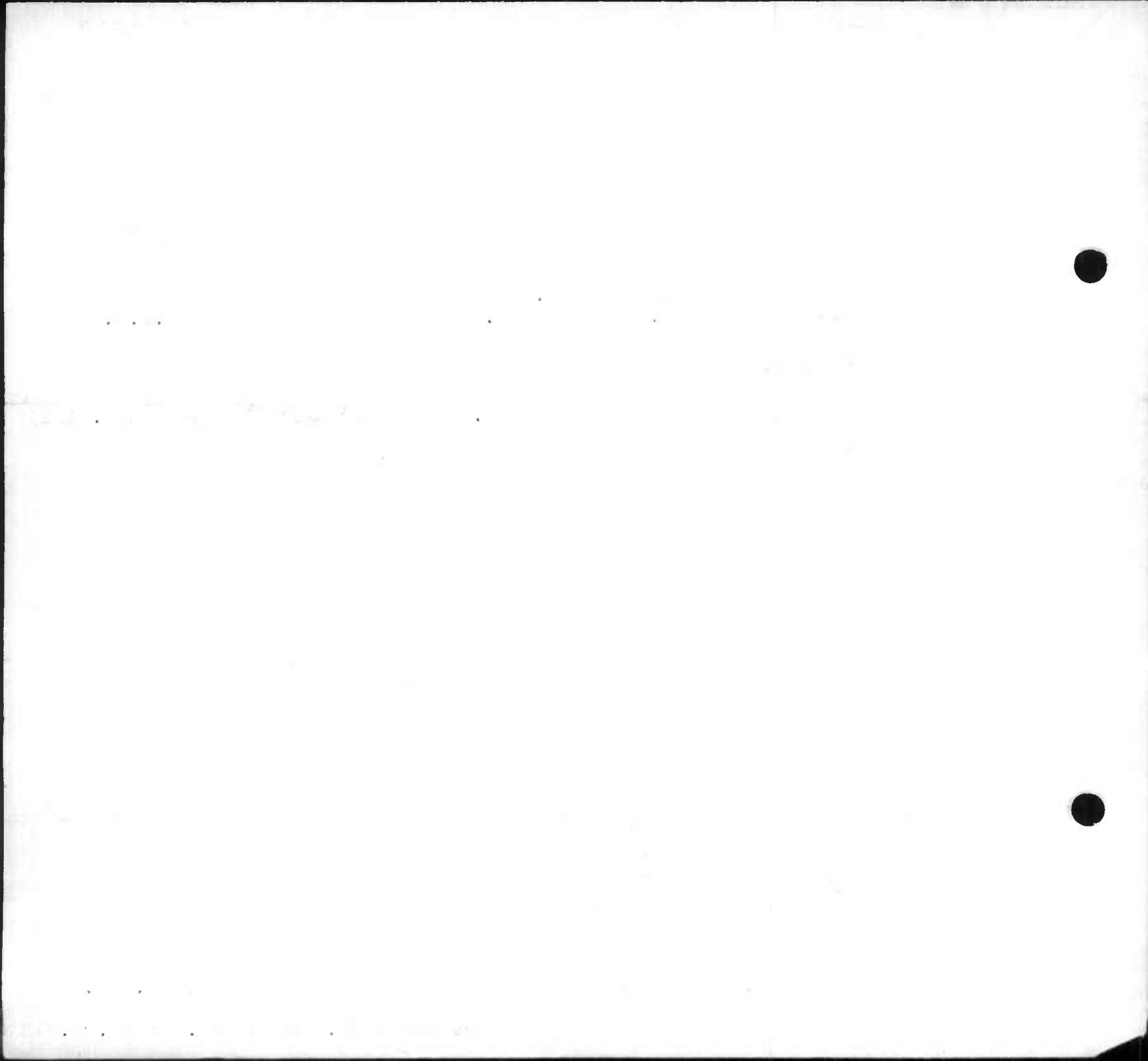
BALTIMORE CITY HEALTH DEPARTMENT				71 8900	
CERTIFICATE OF DEATH				REG. NO. 71 8900	
BIRTH NO. R-200 71 8900				2. DATE AND HOUR OF DEATH Sept. 19, 1971 6 P. M.	
1. NAME OF DECEASED (Type or Print) Lillie M. Rice				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2401	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1462 Stevenson Street				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1462 Stevenson Street					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1887	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Wilder				14. MOTHER'S MAIDEN NAME Emma Hayes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Margaret West 1462 Stevenson Street Balto.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic Heart Disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). -----					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -----	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -----		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----	
22. I certify that (I) (this hospital) attended the deceased from 9/18 19 68 to 9/19 19 71 that (I) (we) last saw the deceased alive on 9/18 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Deibel M.D.				23B. DATE SIGNED 9/21/71	
23C. PHYSICIAN'S NAME (Type) DR HARRY DEIBEL				23D. ADDRESS 1226 S HANOVER STREET BAL, MD 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/23/71		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Faber, M.D.			
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Mc Gully Funeral Home 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

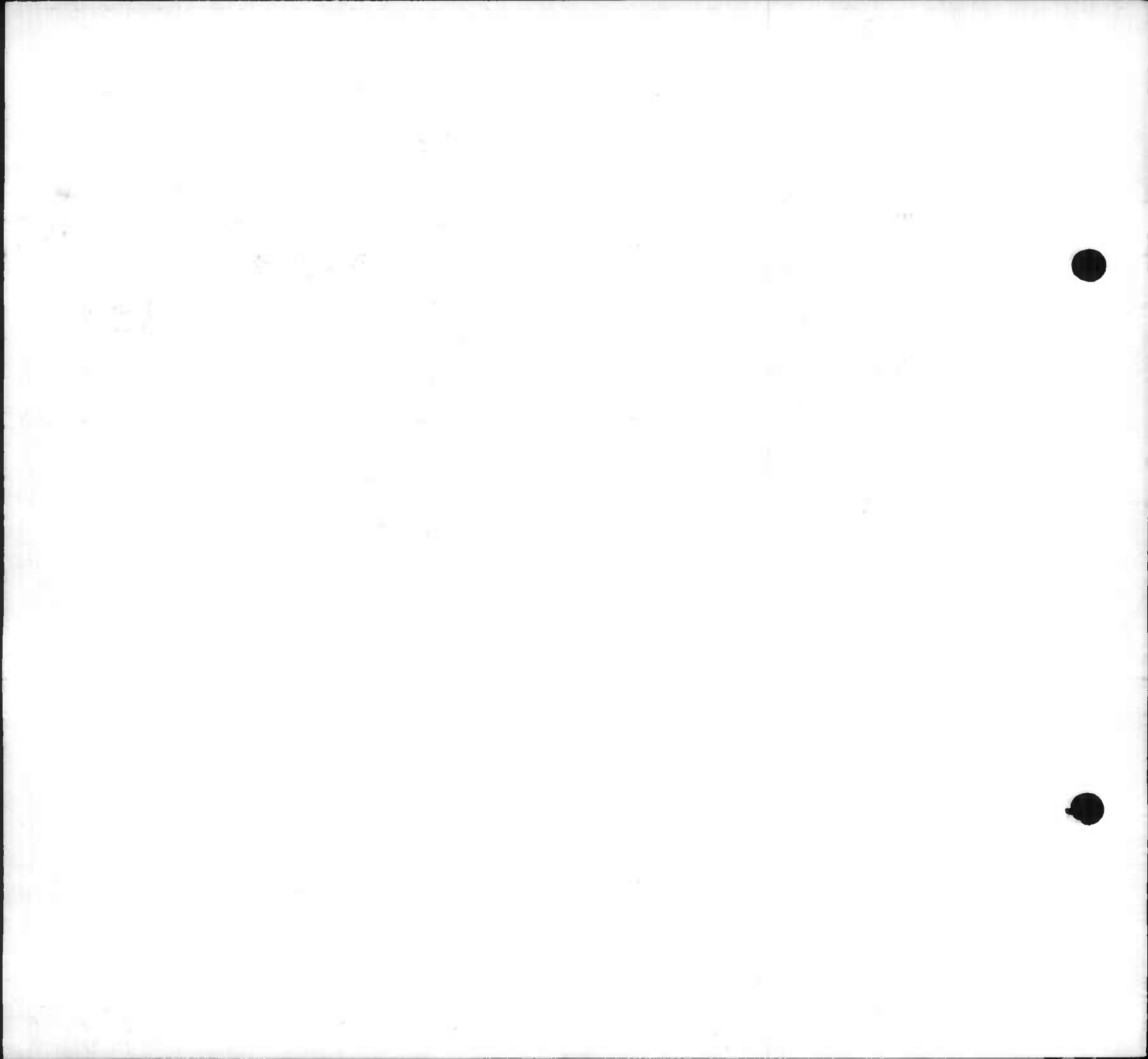
<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		REG. NO. 71 8901	
BIRTH NO. A-350 71 8901			
1. NAME OF DECEASED (Type or Print) Aten, Gorge E.		2. DATE AND HOUR OF DEATH Sept. 19, 1971 8:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2403 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1020 Riverside Ave. 21230	
5. SEX Male	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1906
9. AGE (In years last birthday) 64		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) License Reviewer		10B. KIND OF BUSINESS OR INDUSTRY State of Md. Dept. of Motor Ve.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank. Aten		14. MOTHER'S MAIDEN NAME Ida Mills	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 11		16. SOCIAL SECURITY NO. 218-05-4396	
17. INFORMANT E. Elsie Aten		ADDRESS 1020 Riverside Ave. 21230	
18. 1997 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Terminal Ca. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from Sept. 19 19 71 to Sept. 19 19 71 that the (we) last saw the deceased alive on Sept. 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death.			
23A. SIGNATURE Chiu Sung Chan M.D.		23B. DATE SIGNED Sept. 19, 1971	
23C. PHYSICIAN'S NAME (Type) Chiu Sung Chan.		23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/23/71	24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	24D. LOCATION (City, town, or county) (State) Ritchie Hghw Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971	25B. NAME OF REGISTRAR R. E. Fally, MD.	25C. FUNERAL DIRECTOR Krause	
ADDRESS 12166 Charles St. Balto. Md. 21230			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

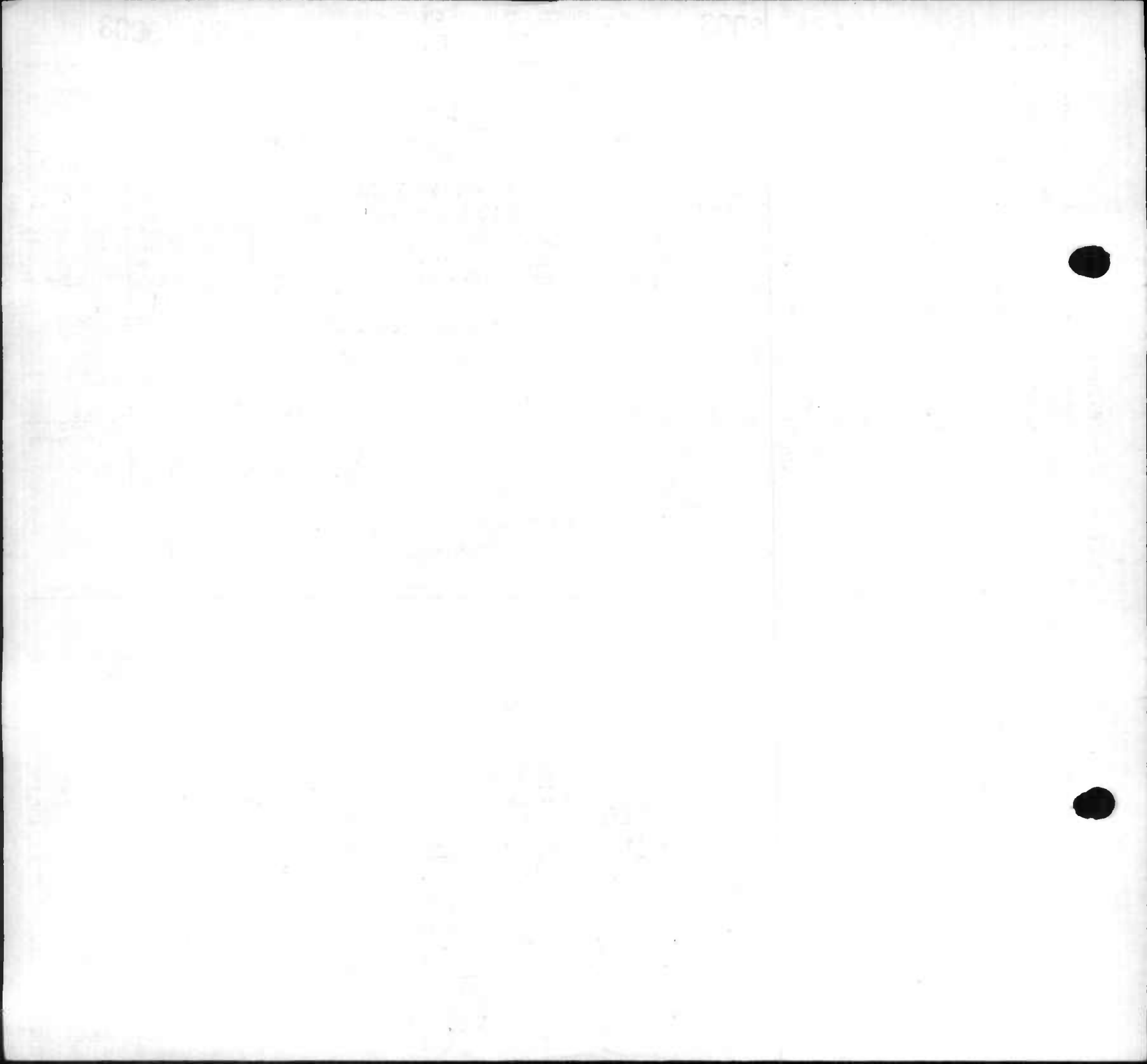
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 8902</u>	
S-540 71 8902		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SMALL, LOUIS</u>		2. DATE AND HOUR OF DEATH <u>Sept. 18 1971</u> <u>4:25 P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hosp</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2740</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5913 Winner Ave.</u> <u>21215</u>	
5. SEX <u>MALE</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15 - 1906</u> 9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvis</u>		14. MOTHER'S MAIDEN NAME <u>Rosa</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-9958</u>	
17. INFORMANT <u>Mrs Gertrude Small</u>		ADDRESS <u>Some</u>	
18. <u>284 XI</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Pul. edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHF - PACE-MAKER</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Aplastic Anemia</u> (C) <u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>C. Thananopavan</u> M.D.		23B. DATE SIGNED <u>Sept 18, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHALEMPHOL THANANOPAVARN M.D.</u>		23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE INC</u>	
24A. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/19/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>		24D. LOCATION (City, town, or county) (State) <u>Balta Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>		25B. NAME OF REGISTRAR <u>Robert C. Fisher M.D.</u>	
25C. FUNERAL DIRECTOR <u>Harold Lewis & Son</u>		ADDRESS <u>9610 Reisterstown</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

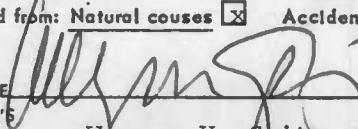
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8903	
B-65271 8903		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Marcus M. Bernstein, JR			2. DATE AND HOUR OF DEATH Sept 20, 1971 9:20 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Pikesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3906 Naylor's Lane		
5. SEX Male	6. RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/08	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Marcus Berstein			14. MOTHER'S MAIDEN NAME Marion Stromberg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W U II		16. SOCIAL SECURITY NO. 215-10-6347	17. INFORMANT Mrs. Caroline Bernstein ADDRESS Same		
18. 155X1			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory Arrest 5 min (B) Metastatic Carcinoma Prostate DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Sept 12 19 71 to Sept 20 19 71 that (H) (we) lost saw the deceased alive on 9:20am Sept 20 19 71 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry Cooper MD				23B. DATE SIGNED Sept 20, 1971	
23C. PHYSICIAN'S NAME (Type) Barry Cooper, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/71		24C. NAME of CEMETERY or CREMATORY Balto Hebrew	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971			
25B. NAME OF REGISTRAR John E. Taylor, MD		25C. FUNERAL DIRECTOR John E. Taylor		25D. ADDRESS 9610 Reisterstown Rd	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8904

BIRTH NO.

1. NAME OF DECEASED (Type or Print) S. Lenorard Anuszewski		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 21 71 6:45 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 613 Annabell Avenue		3. DATE PRONOUNCED DEAD Month Day Year 9 21 71 6:45 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 1, 1914		10. AGE (In years lost birthday) 57	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Anuszewski		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		15. MOTHER'S MAIDEN NAME Lena Lentz	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215 09 6275	
18. INFORMANT Catherine Anuszewski (same)		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE  M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 9-21-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/24/71	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hgwy. Baltimore, Md	

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[Faint, mostly illegible text spanning the main body of the page, possibly bleed-through from the reverse side.]

[Handwritten signature or initials in the bottom right area.]

1004

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
P-536 71 8905					REG. NO. 71 8905				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Wilma Viola Pindor					2. DATE AND HOUR OF DEATH Sept. 20 th 1971 9 ³⁰ P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (Pindor)					4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 1703				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 826 Edmondson Ave.					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 826 Edmondson Ave.				
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20 th 1901	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Md.				
13. FATHER'S NAME Walter Young					14. MOTHER'S MAIDEN NAME Eliza Cornish				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Nella Biggs 1035 Argyle Ave.			ADDRESS	
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ??				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/10 1971 to 9/20/71 1971, that (I) (we) lost saw the deceased alive on 9/19/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE W. Garner					23B. DATE SIGNED 9/21/71				
23C. PHYSICIAN'S NAME (Type) W. GARNER					23D. ADDRESS 1133 Penna ave Baltimore				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-25-71			24C. NAME OF CEMETERY or CREMATORY Bethel Cem.			24D. LOCATION (City, town, or county) (State) Cambridge Md.
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1971			25B. NAME OF REGISTRAR D. Wilson			25C. FUNERAL DIRECTOR 1000 Brantley Ave			ADDRESS

10/2/9

10/2/9

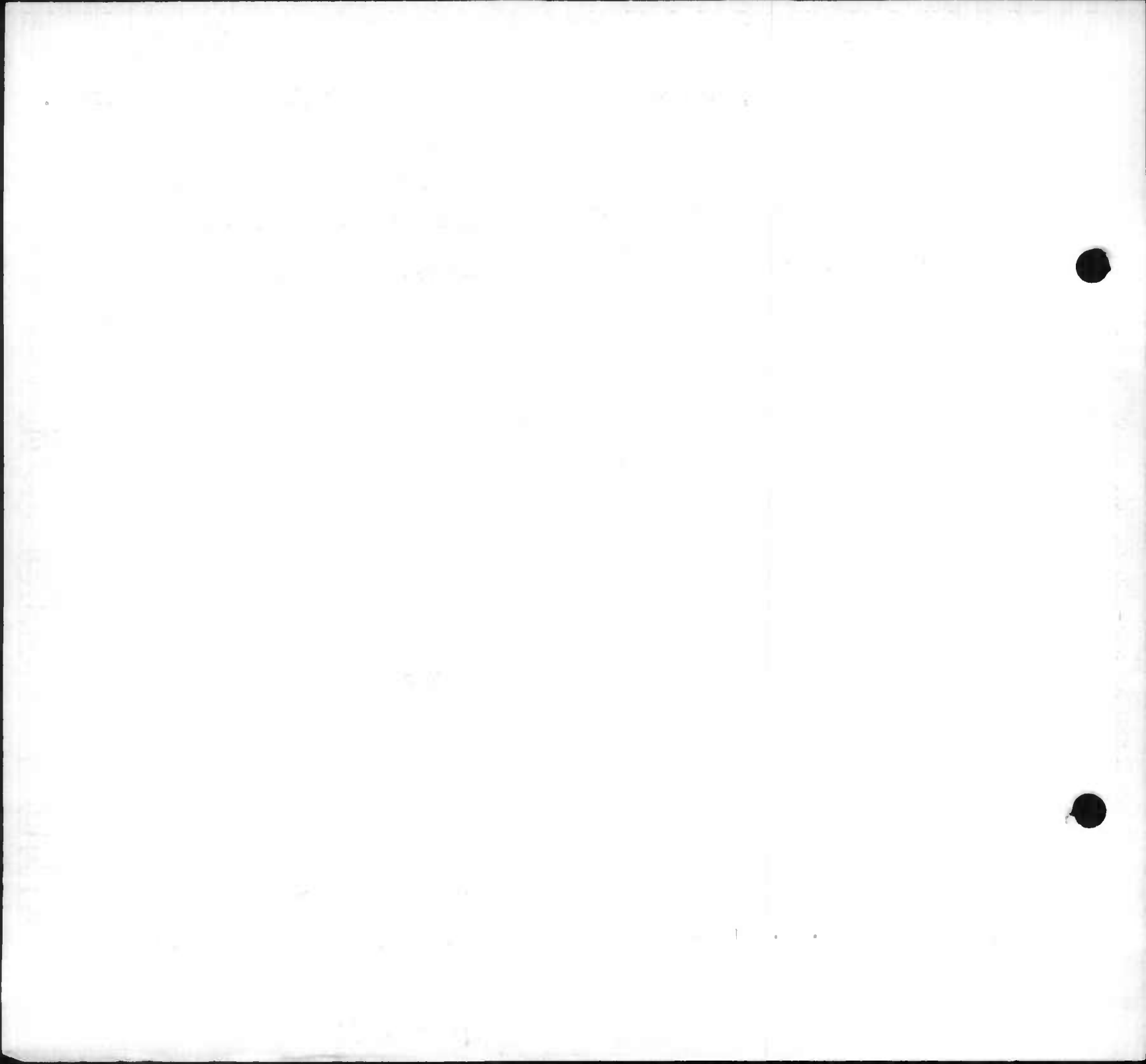
10/2/9

10/2/9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

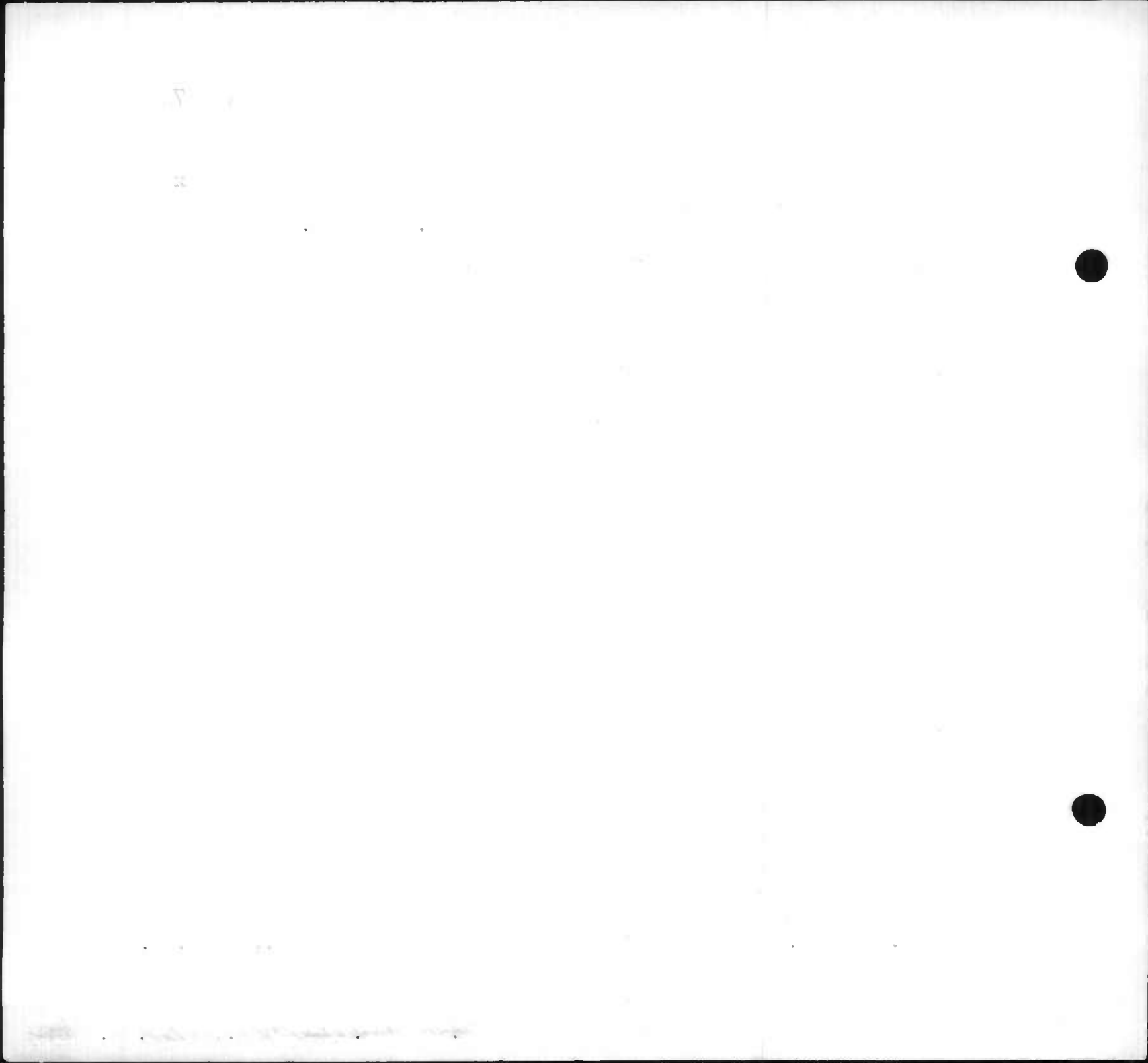
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8906</u>	
BIRTH NO. <u>L-200 71 8906</u>					
1. NAME OF DECEASED (Type or Print) <u>LEACH, George</u>		2. DATE AND HOUR OF DEATH <u>9/20/71</u> <u>4:30 p.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>808</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1035 McDonough Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/05</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John Leach</u>		14. MOTHER'S MAIDEN NAME <u>Rozzie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-1145</u>		17. INFORMANT <u>Lossie Leach Lewis</u>	
18. <u>42221</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>etiology unknown</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9/20</u> 19 <u>71</u> to <u>9/20</u> 19 <u>71</u> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>NEVER</u> 19 _____ and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>R. A. Rizza</u>		23B. DATE SIGNED <u>69-21-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>R. A. RIZZA</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-25-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Not known</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>		25B. NAME OF REGISTRAR <u>R. A. Rizza</u>		25C. FUNERAL DIRECTOR <u>10700 Brantly Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

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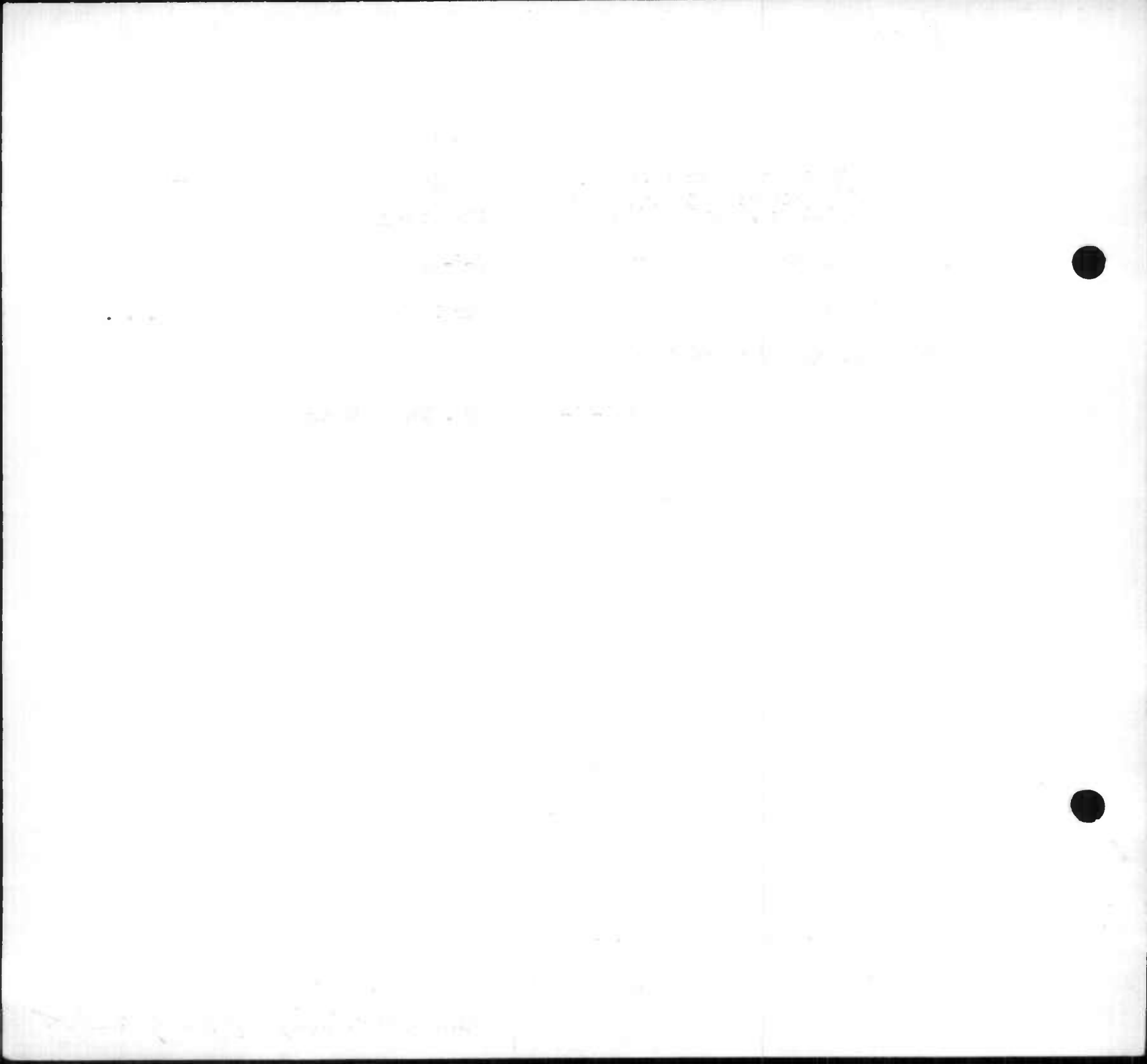
K-36271 8907		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 71 8907	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Vincent Koterwas		September 21, 1971 3:55 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Delaware		V07	
Harford Gardens Conv Home		C. CITY OR TOWN Wilmington		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 714 W. 11th St.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1885	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY NATIONAL FIXTURES		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME LAWRENCE KOTERWAS		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 222 01 4952		17. INFORMANT STANLEY KOTERWAS	
		ADDRESS 2213 LOMBARD ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH I Arteriosclerotic Cardio-Vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 23 1971 to Sept. 19 71 that (I) (we) last saw the deceased alive on Sept. 20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Loy M. Zimmerman M.D.		23B. DATE SIGNED 9/21/71		23C. PHYSICIAN'S NAME (Type) Dr. Loy M. Zimmerman	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-23-71		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cem. Dundalk, Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Talley M.D.		25C. FUNERAL DIRECTOR John M. Weber & Sons Inc. S. Chester	



FUNERAL DIRECTOR: IMPORTANT

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<p>B-463 71 8908</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8908</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print) BALLARD, ESTELLA</p>		<p>Sept. 20 1971 11:00 P. M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1537</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital Complex 2600 Liberty Heights Avenue Baltimore, Maryland 21215</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX Female 6. RACE Black 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 5-6-96 9. AGE (in years last birthday) 75 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME William Wallace</p>		<p>14. MOTHER'S MAIDEN NAME Lou Simms</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 107-14-0641</p>	
<p>17. INFORMANT Mrs. Irene Shavers</p>		<p>ADDRESS Same</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Shock</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Shock DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Diabetic Ketoacidosis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Abdominal Tumor possibly malignant with metastases, primary site unknown</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hours.</p>		<p>19. DATE OF OPERATION 9-20-71 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (his hospital) attended the deceased from 9-20 19 71 to 9-20 19 71 that (I) (we) last saw the deceased alive on 9-20 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE Rhonda C. Tumanon, M.D. DEGREE</p>		<p>23B. DATE SIGNED 9-21-71</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. Tumanon M.D. DEGREE</p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/25/71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Crown Mount 24D. LOCATION (City, town, or county) MURKIN MD (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971 25B. NAME OF REGISTRAR E. Taylor, M.D. 25C. FUNERAL DIRECTOR Harold B. Taylor ADDRESS 635 N. Fulton St</p>			



L-40001

8909

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

8909

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK LILLEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> September 21, 1971		Month Day Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION John Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD September 21, 1971		Month Day Year	Hour
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 2, 1922		10. AGE (In years last birthday) 48		11. BIRTHPLACE (State or foreign country) Wadeboro N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Frank Lilly Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Willie Still		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO.	
18. INFORMANT MARY LILLY		19. ADDRESS 1121 N. Caroline ST		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION 9/23/71		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 22, 1971	
33. BURIAL CREMATION, REMOVAL (Specify) Removal		34. DATE 9/23/71		35. NAME of CEMETERY or CREMATORY Wadeboro N.C.	
36. DATE REC'D BY HEALTH DEPT. SEP 23 1971		37. NAME OF REGISTRAR Robert E. Taylor, R.D.		38. FUNERAL DIRECTOR James H. Locks Jr.	
39. ADDRESS 13047 Central Ave					

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VALLEY

AND DEPT. OF AGRICULTURE

0108

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CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAMS, ROOSEVELT

2. DATE AND HOUR OF DEATH

9:30 AM

19/19/71 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

808 N. Monroe St. 21217 007

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-23-30

9. AGE (In years
last birthday)

41

If Under 1 Yr.

If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Operation Champ

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Ernest Williams

14. MOTHER'S MAIDEN NAME

Hester Holloman

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-24-5423

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue
Baltimore, Md. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardio-respiratory arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Acidosis

(C)

Esophageal varices-bleeding/Conthosis

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

September 18 1971 to September 19 1971

that (I) (we) last saw the deceased alive on

September 19 1971 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/19/71

23D. ADDRESS

4940 Eastern Avenue
Baltimore, Maryland 2122424A. BURIAL CREMATION, 24B. DATE
REMOVAL (Specify)

Burial

9-23-71

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 23 1971

25B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

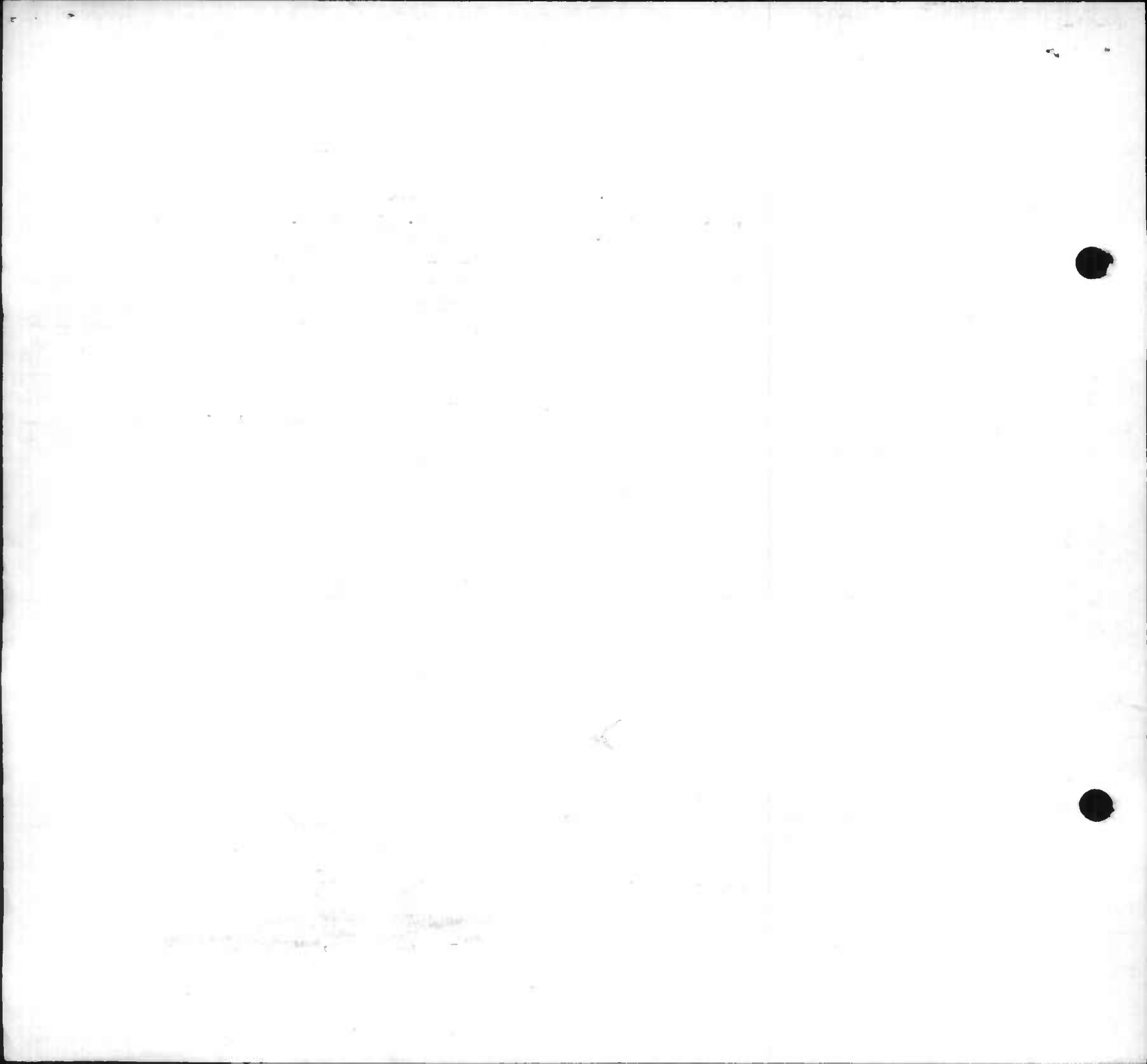
25C. FUNERAL DIRECTOR

Kedison R.H. 71348 Calhoun Street

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

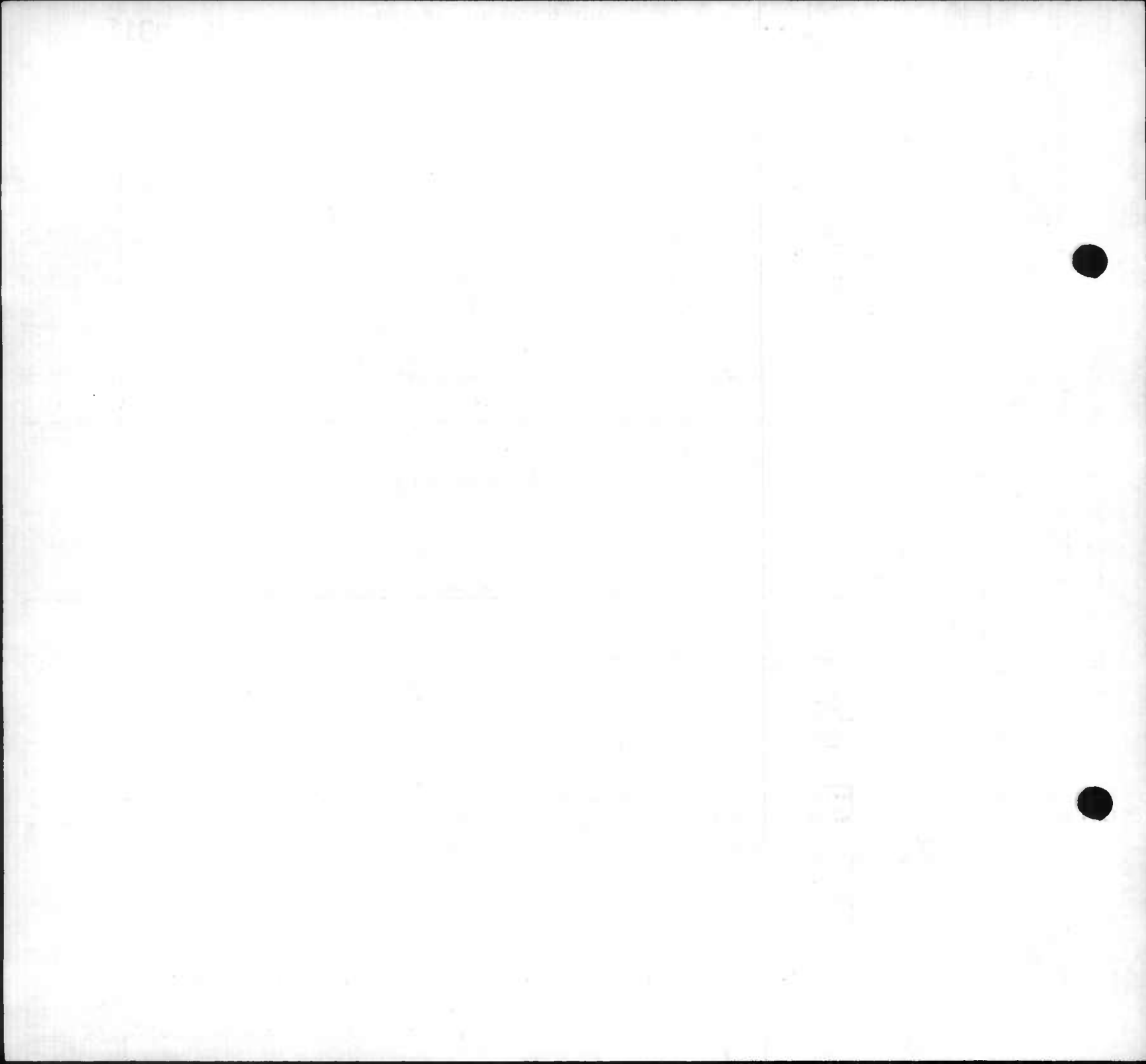
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8911</u>	
BIRTH NO. <u>71 8911</u>							
1. NAME OF DECEASED (Type or Print) <u>Irene H. Perzinski</u>				2. DATE AND HOUR OF DEATH <u>9/21/71</u> <u>11</u> <u>10</u> <u>P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2605</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>400 Drew St. #21224</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/30/28</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Baranowski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-22-0833</u>		17. INFORMANT <u>HARRY PERZINSKI</u>		ADDRESS <u>SAME</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Malignant Melanoma Metastasis to Brain and Abdomin</u> DISEASE OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ANTCEDENT CAUSES</u> <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <u>Malignant Melanoma Metastasis to Brain and Abdomin</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>	
19A. DATE OF OPERATION <u>9/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>71</u> to <u>9/21</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. H. Ziegler MD</u>				23B. DATE SIGNED <u>9/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>J. H. Ziegler</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>9-25-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>7225 EASTERN BLVD., BALTO., MD.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>			
25B. NAME OF REGULAR MEDICAL OFFICER <u>Charles J. Jelen</u>				25C. FUNERAL DIRECTOR ADDRESS <u>6224 EASTERN AVE. BALTO., 21224, MD.</u>			



FUNERAL DIRECTOR: IMPORTANT

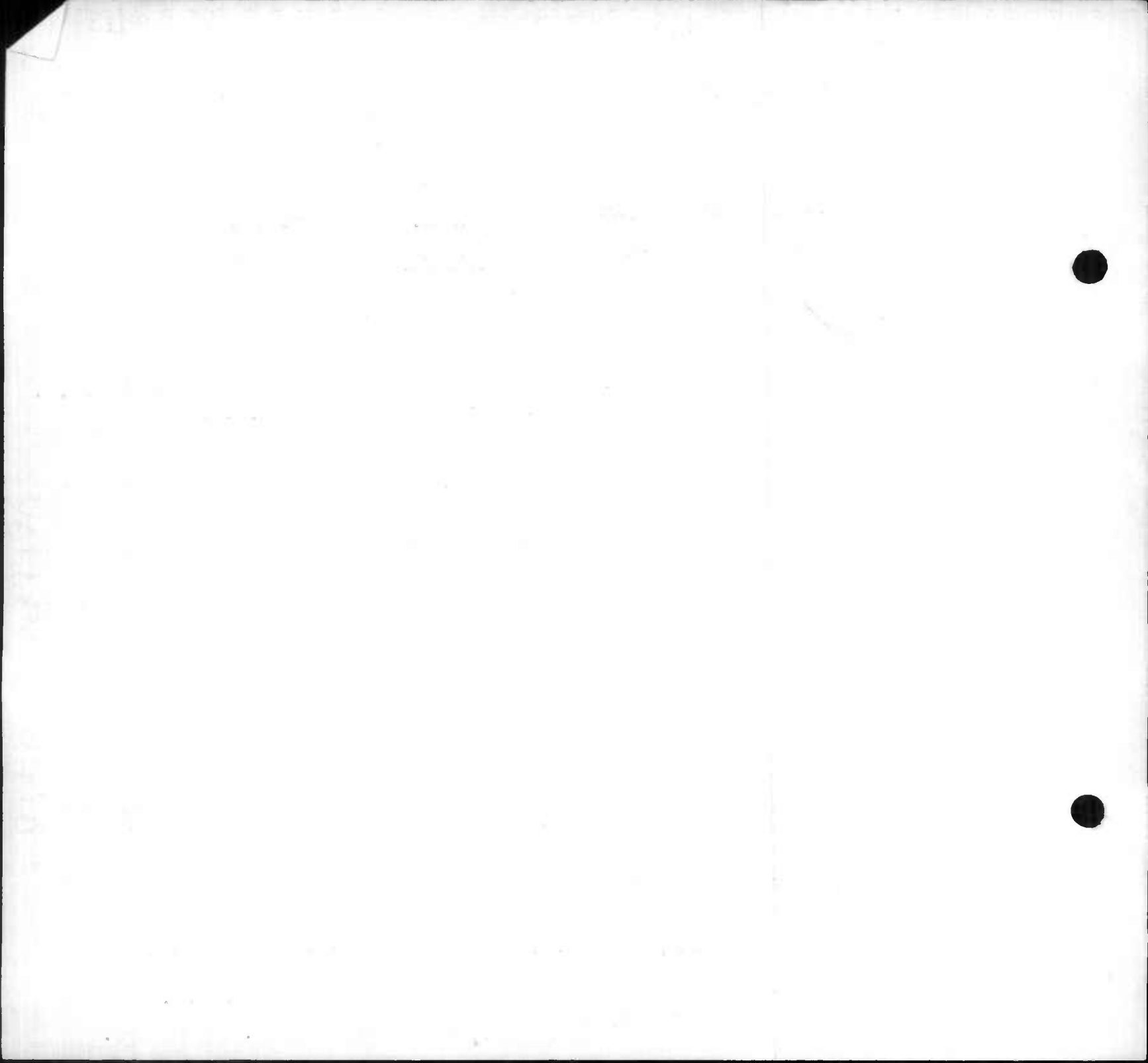
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-200 71, 8912		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8912	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Robert T. Wise</u>		2. DATE AND HOUR OF DEATH <u>9-18-71</u> <u>6:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1606</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran</u>		C. CITY OR TOWN <u>Baltimore, MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2822 Harlem Ave</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-39</u>	9. AGE (In years lost birthday) <u>32</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Harold Wise</u>		14. MOTHER'S MAIDEN NAME <u>Cloethe Pancy</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-4194</u>		17. INFORMANT <u>Harold J. Wise</u> ADDRESS <u>2822 Harlem Ave</u>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uræmia</u>		<u>1 wk</u>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Uræmia</u>		<u>1 wk</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Uræmia</u>		<u>1 wk</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>9-14-</u> 19 <u>71</u> to <u>9-19-</u> 19 <u>71</u>		that (1) <u>we</u> last saw the deceased alive on <u>9-19-</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) (did not) view the body after death.	
23A. SIGNATURE <u>Jason Samuel</u> M.D., DEGREE		23B. DATE SIGNED <u>9-19-71</u>		23C. PHYSICIAN'S NAME (Type) <u>JASON SAMUEL</u> DEGREE	
23D. ADDRESS <u>730, Ashburton St., Baltimore MD-21216</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burn</u>		24B. DATE <u>9/23/71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION <u>Bolte MD.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1971</u>	
24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		24G. FUNERAL DIRECTOR <u>Wm C March</u>		24H. ADDRESS <u>928 E NORTH AVE</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

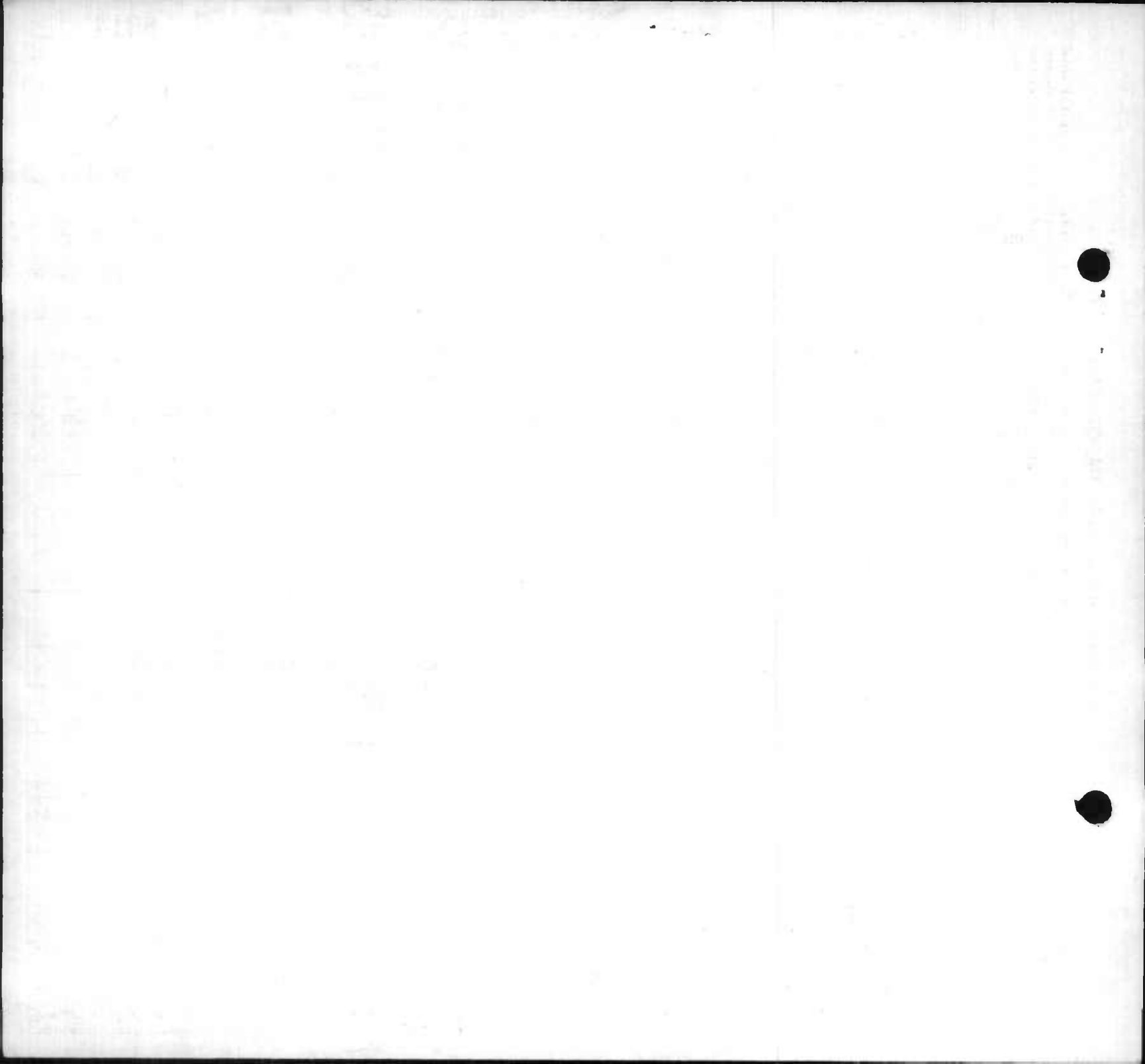
S-530 71 8913		BALTIMORE CITY HEALTH DEPARTMENT		71 8913	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) SMITH, Otis			2. DATE AND HOUR OF DEATH Sept 21, 1971 3:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence below admission) A. STATE Maryland B. COUNTY 604		
5. SEX M			6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Jesse Smith			14. MOTHER'S MAIDEN NAME Ida Cox		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 257-14-5512		17. INFORMANT Allie Washington P.O. Box 238 Winterville, N.C.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Sept 19 1971 to Sept 21 1971 that (I) (we) last saw the deceased alive on Sept 21 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE James A. Martin 23B. DATE SIGNED 9-21-71 23C. PHYSICIAN'S NAME (Type) James Martin, M.D. 23D. ADDRESS The Johns Hopkins Hospital 24A. BURIAL CREMATION REMOVAL (Specify) Burial 24B. DATE 9-26-71 24C. NAME OF CEMETERY OR CREMATORY Winterville, N.C. 24D. LOCATION (City, town, or county) (State) Winterville, N.C. 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Wm. C. March ADDRESS 928 E. North Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8914</u>	
W-300 71 8914		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THERESA M. WOOD		SEPTEMBER 22-71 8:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL			A. STATE MDRULAND		
			B. COUNTY 907		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2609 GARRETT AVE.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/22/52		9. AGE (In years last birthday) 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JESSE WOOD			14. MOTHER'S MAIDEN NAME EVELYN (WOOD) BARNES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS EVELYN WOOD 2609 GARRETT AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E9-31-21 ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF: (B) FULMINANT HEPATITIS DUE TO, OR AS A CONSEQUENCE OF: (C) SERUM HEPATITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) UNION MEM HOSP 12-02	
21D. TIME OF INJURY (APPROX.) 4-5-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? APPARENTLY TRANSFUSION HEPATITIS	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 20 1971 to SEPTEMBER 22 1971 that (I) (we) lost saw the deceased alive on SEPTEMBER 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar Villan				23B. DATE SIGNED 9/21/71	
23C. PHYSICIAN'S NAME (Type) CESAR VILLAN INTERN DEGREE				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-26-71		24C. NAME OF CEMETERY OR CREMATORY ARBOTUS MEM PARK	
				24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS WY9-C1 MARCH 928 E. NORTH AVE	



71 8915
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8915

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROOSEVELT KELLY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Sept. 17, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour Sept. 17, 1971 6:00 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2037	
9. DATE OF BIRTH Oct. 7, 1948		10. AGE (In years lost birthday) 22	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Kelly		14. MOTHER'S MAIDEN NAME Niza Austin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215-46-8493	
17. INFORMANT Mr. & Mrs. Leroy Kelly		18. ADDRESS 403 N. Edgewood Street	

19. 304.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF:		
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		DATE SIGNED 9-18-71

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

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71

8916

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71

8916

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERNELL CARTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 1971 2:12 p M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2717	
9. DATE OF BIRTH 4-22-06		10. AGE (In years last birthday) 65 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Carter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver	
15. MOTHER'S MAIDEN NAME Frances Jones		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-03-3510		18. INFORMANT ADDRESS Mrs. Sadie Brown Carter 2434 Lafayette Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute massive pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9-19-71		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9-23-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street	

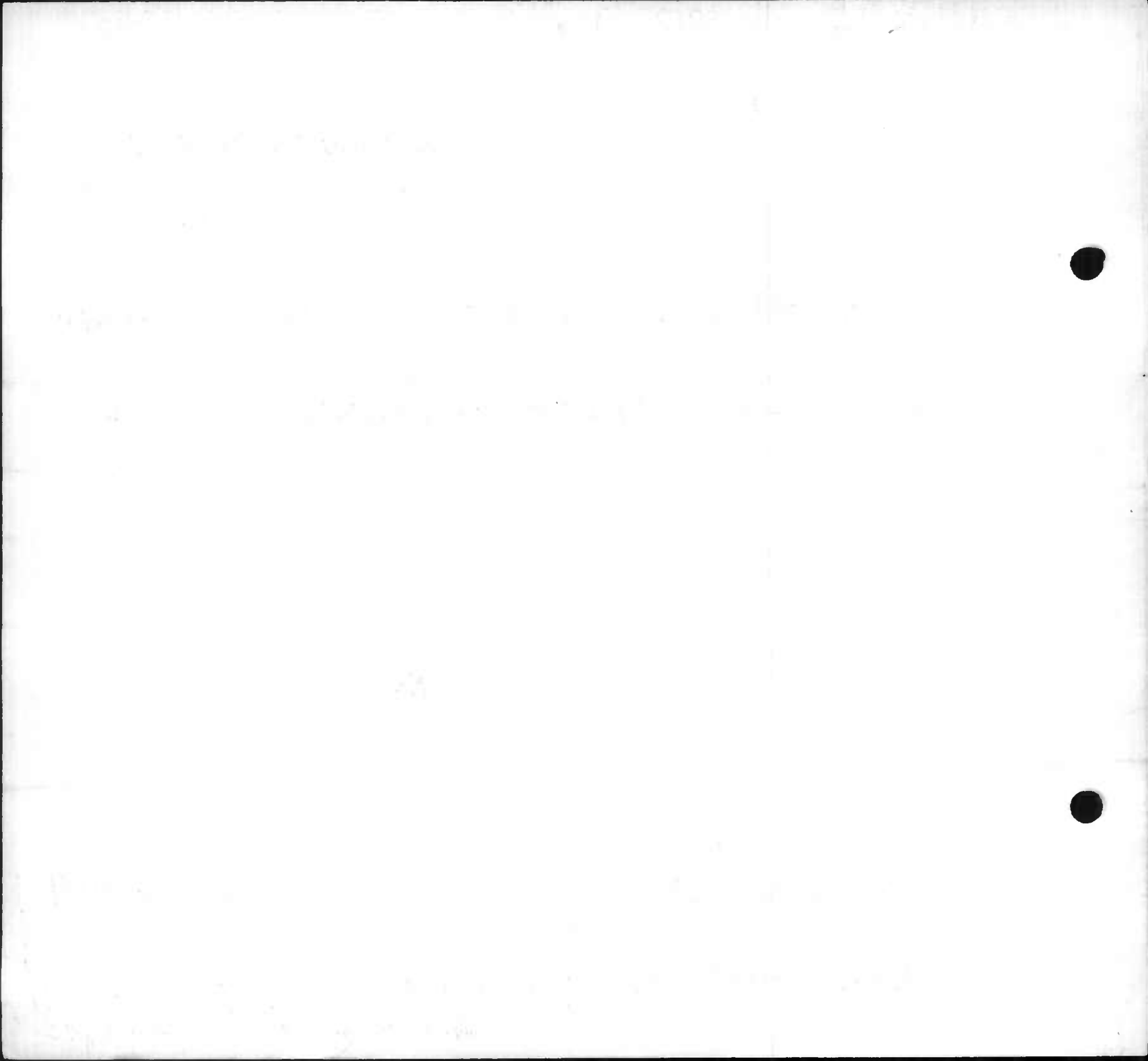
4-22-11

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460 71 8917		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 8917	
1. NAME OF DECEASED (Type or Print) TAYLOR, BERNARD RUSSELL		2. DATE AND HOUR OF DEATH 9. 21. 71. 9. A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL. 38 BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY WICOMICO C. CITY OR TOWN SALISBURY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RIAWAKIN Dr Rt. #5			
5. SEX Male	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2. 29. 20.	9. AGE (In years last birthday) 51 YRS	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CorrecTIAL OFFICER STATE MARYLAND		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN. M. TAYLOR.		14. MOTHER'S MAIDEN NAME BESSIE TAYMAN.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-16-1219		17. INFORMANT MRS. MARY A. TAYLOR See Sec 4	
18. 71231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST. (B) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7. 23. 71.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY OCCLUSION.		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8. 31. 1971 to 9. 21. 1971 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gopalakrishnan		23B. DATE SIGNED 9-21-1971		23C. PHYSICIAN'S NAME (Type) DR. GOPALA KRISHNAN	
23D. ADDRESS UNIVERSITY HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 9-24-1971		24C. NAME OF CEMETERY or CREMATORY Wicomico Memorial PARK		24D. LOCATION (City, town, or county) (State) SALISBURY, WICOMICO, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 23 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. BAKER-Balch's Home	
25D. ADDRESS SALISBURY, Md.					



H-400

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8918

71 8918

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JULIUS HALL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 23, 1971 5:30 AM	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1402	
9. DATE OF BIRTH 1/13/50		10. AGE (In years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN HALL		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME NATHALIE		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO.		18. INFORMANT MRS NATHALIE HALL, SAME	
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Bronchopneumonia and Cerebral Anoxia (A) MODERATE DOSE complicating Narcotic Addiction DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/23/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/27/71	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north Ave	

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

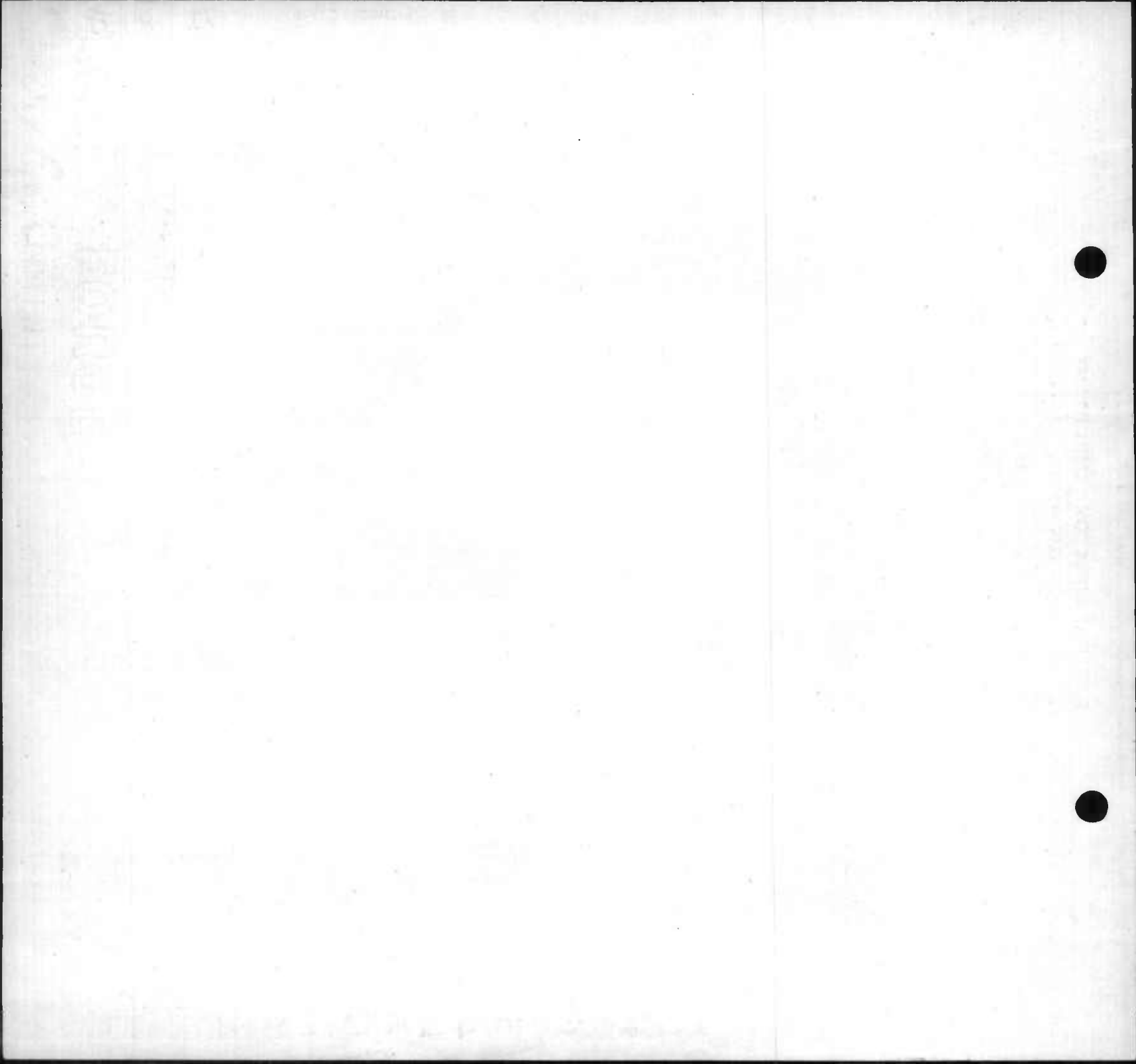
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8919
<div style="font-size: 1.5em; font-weight: bold;">R-324715585</div>		<div style="font-size: 1.5em; font-weight: bold;">71 8919</div>		
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Ridgely "Twin A"</i>		2. DATE AND HOUR OF DEATH <i>8/30/71 8:10 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore General Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>AA</i> B. COUNTY <i>5200</i> C. CITY OR TOWN <i>Glen Burnie</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>204 Pelican Dr.</i>		
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/27/71</i>	9. AGE (in years last birthday) <i>3</i> If Under 1 Yr. Months: <i>3</i> Days: <i>3</i> Hours: <i>3</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>Judy Ridgely</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital chart</i> ADDRESS
18. <i>72381</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory Distress Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>8/27</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes.</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (t) (this hospital) attended the deceased from <i>8/27</i> 19 <i>71</i> to <i>8/30</i> 19 <i>71</i> that (t) (we) last saw the deceased alive on <i>8/30</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>James A. Kopper M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/30/71</i>
23C. PHYSICIAN'S NAME (Type) <i>James A. Kopper M.D.</i>		23D. ADDRESS <i>5864</i>		
24A. BURIAL CREMATION REMOVAL (Specify) <i>9-22-71</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. ADDRESS <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8920
CERTIFICATE OF DEATH				X
BIRTH NO. R-324-11-15386 8920				
1. NAME OF DECEASED (Type or Print) Baby Boy & B. Ridgely		2. DATE AND HOUR OF DEATH 8/27/71 10:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY AA		
FULL NAME OF HOSPITAL OR INSTITUTION 43 S BGH		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 1 20
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME Judy Ridgely		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Corp. chart
18. 726.9 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Neonatal Asphyxia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Prematurity		
(C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8-27-71 19 to 8-27-71 19, that (I) (we) last saw the deceased alive on 8-27-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE James A. Kopper MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/27/71
23C. PHYSICIAN'S NAME (Type) James A. Kopper MD		23D. ADDRESS SRGH, ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-22-71		24C. NAME OF CEMETERY or CREMATOR 1
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR SEP 24 1971		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200 71 8921		BALTIMORE CITY HEALTH DEPARTMENT		71 8921	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
William Rose		9/13/71 11 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
many land General Hosp		Maryland Balti. 1703			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1050 Pennsylvania 21201			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
m	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-7-10	60	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
none				Va	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 444-2-3501		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Bacterial Peritonitis			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bowel Infarction			
		(C) Kidney failure			
II		Diabetes mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/9/71 to 9/13/71		that (I) (we) last saw the deceased alive on 9/13/71		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Donald H. Hislop		9/13/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DONALD H. HISLOP		Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATION	
		9-20-71		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 24 1971		R. B. E. Taylor, MD.		UNIVERSITY MEDICAL SCHOOL	
				MORTUARY SERVICE BCHD	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

8922

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY HUGHES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 204 S. Stricker Street		3. DATE PRONOUNCED DEAD Month Day Year Hour September 8, 1971 2:45 P.M.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 80		E. STREET AND NUMBER 204 S. Stricker Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. 412.4 I CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

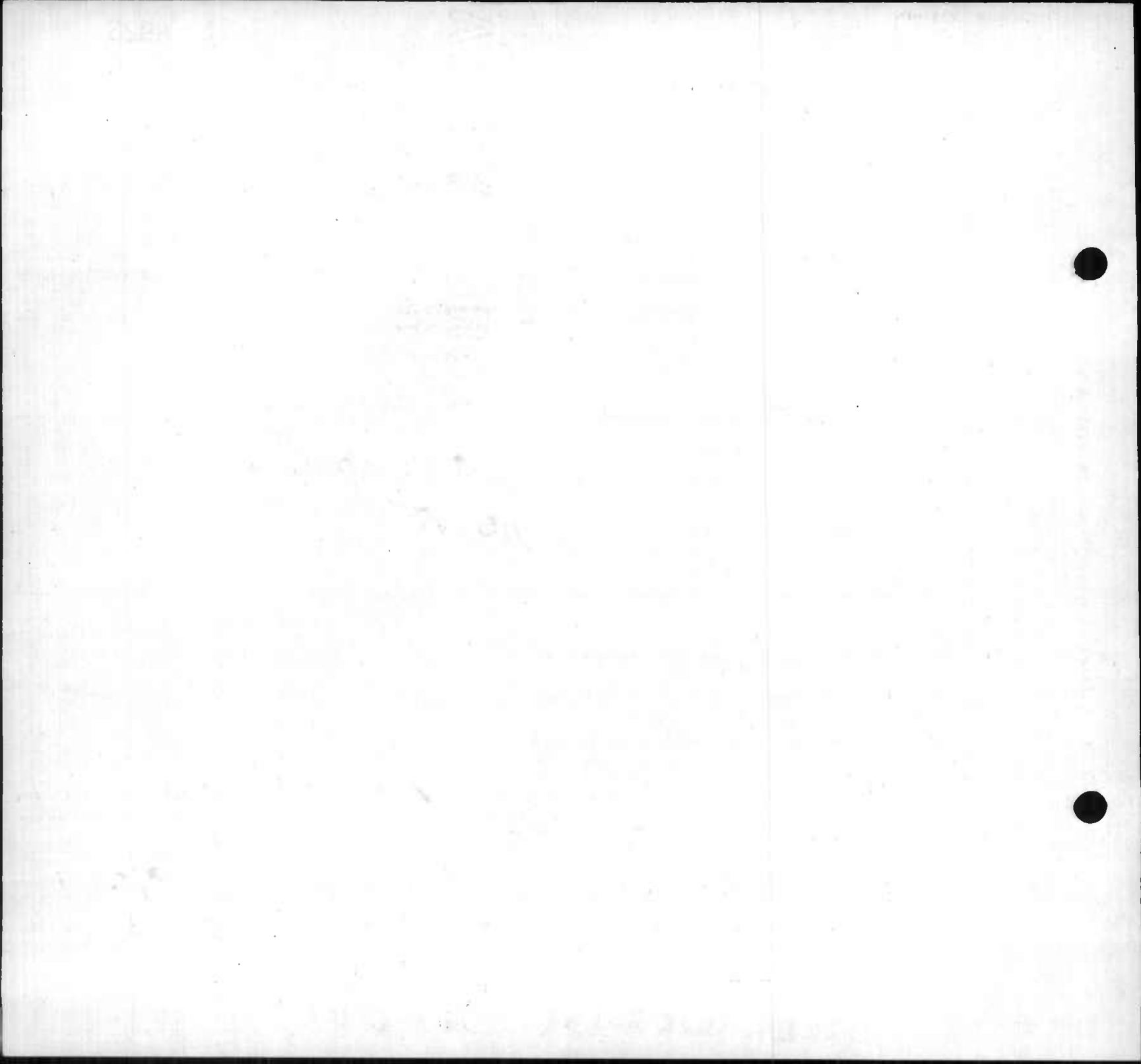
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED September 9, 1971		

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-21-71		24C. NAME OF CEMETERY or CREMATORIUM ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. NAME OF MORTUARY UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8923	
BIRTH NO. 71 8923		1. NAME OF DECEASED (Type or Print) Frances W. Childs		2. DATE AND HOUR OF DEATH 9-22-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1245 Cleveland St			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 26 1907	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Dorsey		14. MOTHER'S MAIDEN NAME Frances Dorsey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 219 03 7908		17. INFORMANT John Childs 1245 Cleveland	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardium acute infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 11 1965 to Sept 19 71 , that (I) (we) last saw the deceased alive on 9/9/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eugenio E. Benitez				23B. DATE SIGNED 9/23/71	
23C. PHYSICIAN'S NAME (Type) Eugenio E. Benitez, M. D.				23D. ADDRESS 3350 Wilkens Ave. Balto 21229 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-71		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Elbridge, Howard Co Md		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR SEP 24 1971		25D. ADDRESS 1600 Bolling			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-240 71 8924 </div>		<div style="display: flex; justify-content: space-between;"> CITY HEALTH DEPARTMENT REG. NO. 71 8924 </div>	
BIRTH NO. 1		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BASIL JR., JOHN HERBERT		2. DATE AND HOUR OF DEATH SEPTEMBER 20, 1971 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; margin-left: 10px;">40</div> ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 207 ALTMONT AVE 21228	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 01 24 9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER (ASSISTANT) CAR DEALER		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. BASIL SR.		14. MOTHER'S MAIDEN NAME MARY (WALLACE)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. 2		16. SOCIAL SECURITY NO. 217 18 3887	
17. INFORMANT XXXXX WILKENS ADDRESS 1229		ST AGNES HOSPITAL RECORDS CATON &	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Metastasis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CA Lung Bronchoogenic Carcinoma	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 8-2-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from JULY 23 1971 to SEPTEMBER 20 1971 that (I) (we) last saw the deceased alive on SEPTEMBER 20 1971 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Alal Qureshi		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR QURESHI		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-1971	
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert F. [Signature]	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

BIRTH NO.		1. NAME OF DECEASED (Type or Print) George Tote		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 21 71 12:13 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2747 Maryland Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 21 71 12:13 A.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1206	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH March 4, 1931		10. AGE (in years lost birthday) 40	E. STREET AND NUMBER 2747 Maryland Avenue		
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME John Tote		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Industrial	15. MOTHER'S MAIDEN NAME Hallie Allie		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean War		17. SOCIAL SECURITY NO. 232-42-8957	18. INFORMANT (Brother) ADDRESS David T. Tote 1405 Park Avenue Balto. 17 Md.		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 9/24/71					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. DATE OF OPERATION 9/24/71					21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/24/71	24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. Anne Arundel
25A. DATE RECEIVED BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS McCully Funeral Home 130 E. Fort Avenue	

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STATE OF NEW YORK

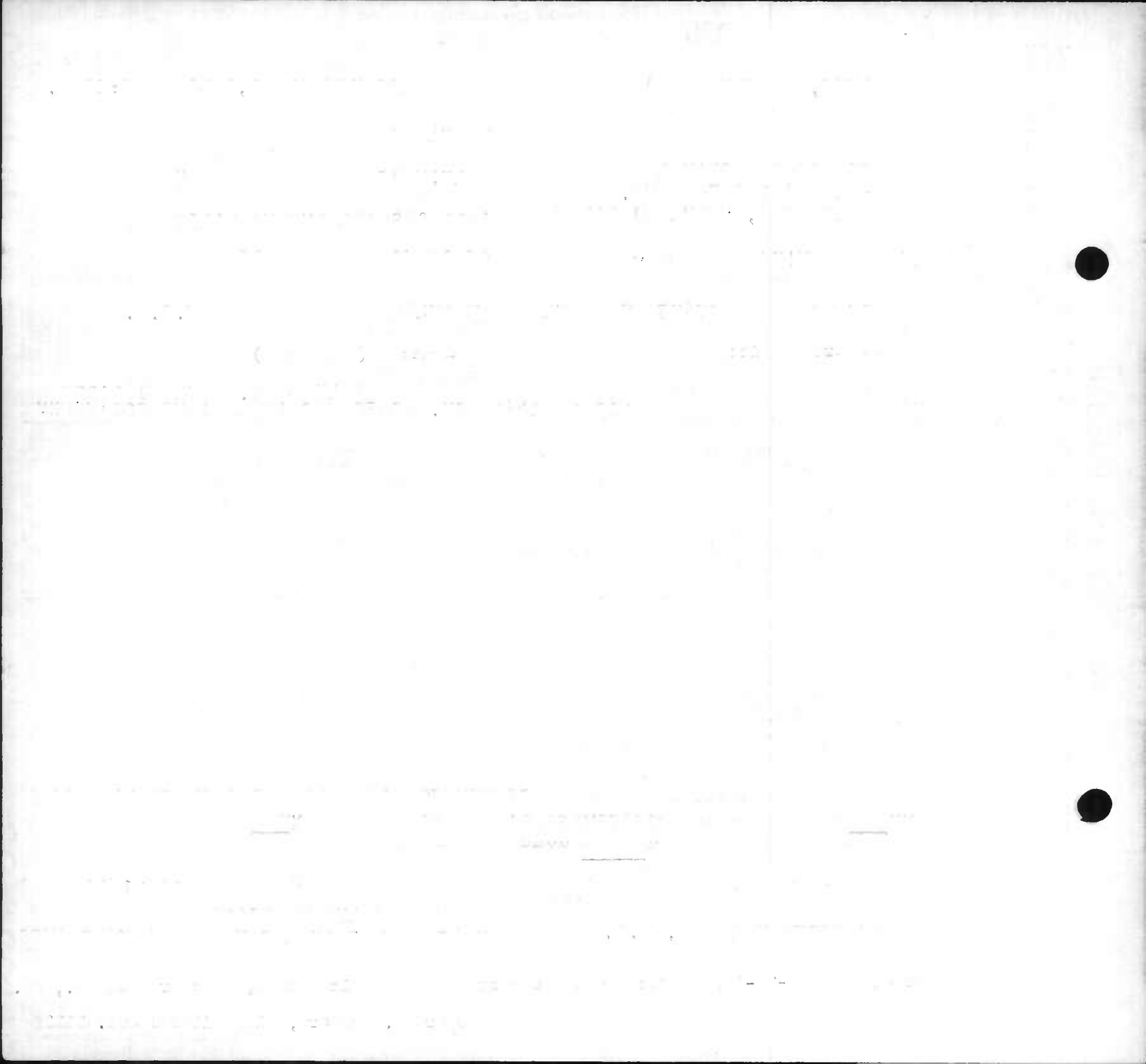
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[Faint, illegible text from bleed-through of the reverse side of the page, including what appears to be a signature and various lines of text.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

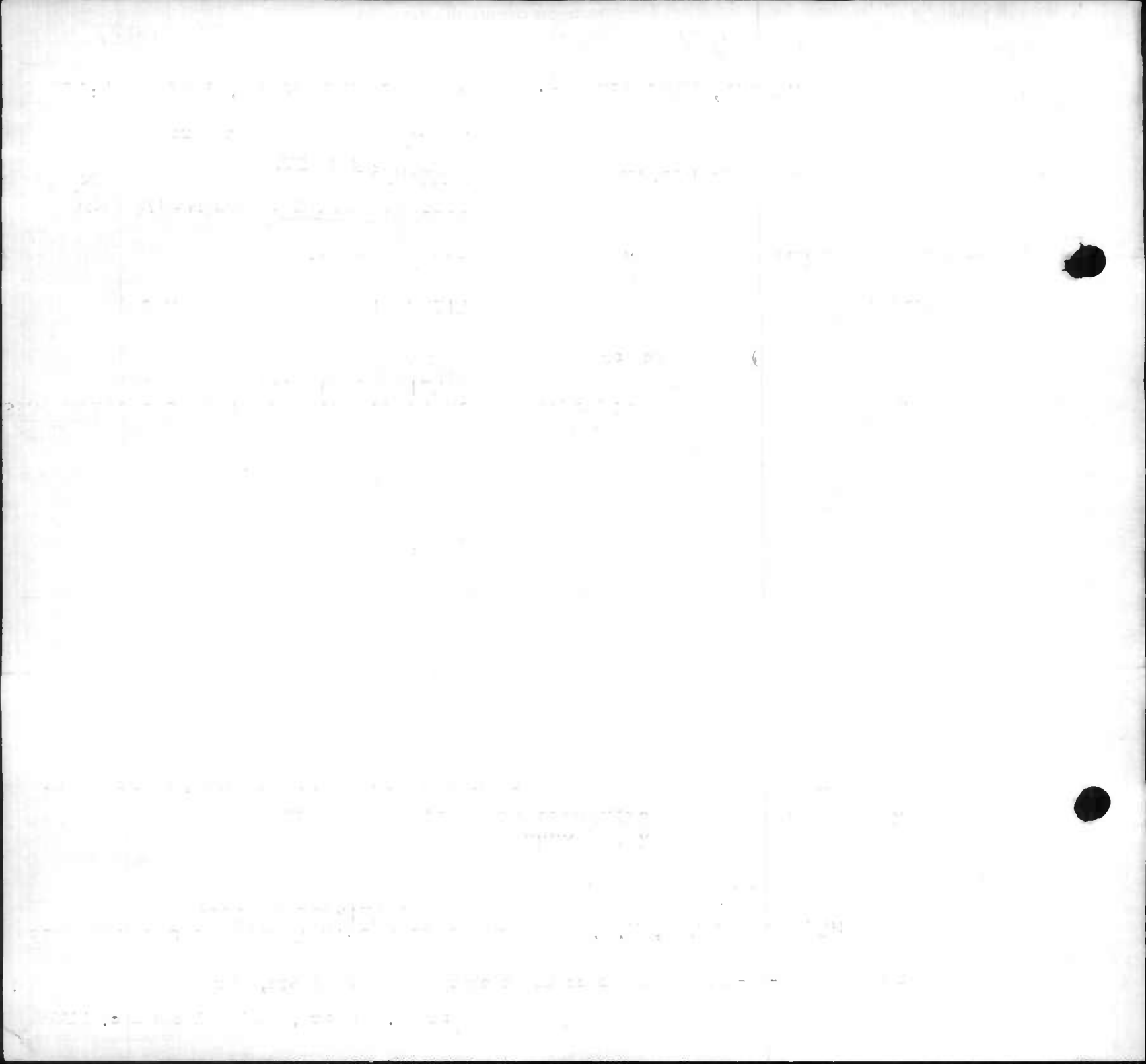
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8926</u>	
BIRTH NO. <u>D-300 71 8926</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DITTY, ROBERT (NMN)</u>		2. DATE AND HOUR OF DEATH <u>SEPTEMBER 21, 1971</u> <u>5:50 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> <u>WILKENS & CATON AVE.</u> <u>BALTIMORE, MARYLAND 21229</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>2582</u>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1927 CASADEL AVENUE 21230</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05 19 01</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STATE OF MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Robert Ditty</u>			14. MOTHER'S MAIDEN NAME <u>Agnes (Unknown)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 20 3469</u>		17. INFORMANT <u>BALTIMORE, MARYLAND 21229</u> <u>ST. AGNES HOSPITAL WILKENS & CATON</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of the Lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 18 19 71</u> to <u>SEPTEMBER 21 19 71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>SEPTEMBER 21 19 71</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Perfecto Valarao</u>				23B. DATE SIGNED <u>09/21/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>PERFECTO VALARAO, M.D.</u>				23D. ADDRESS <u>BALTO MD 21229</u> <u>ST AGNES HOSPITAL CATON & WILKENS AVES</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-24-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Anne Arundel Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. J. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8927</u>	
<p>P-420 71 8927</p> <p>BIRTH NO.</p>		<p>CERTIFICATE OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">PULASKI, MARGARET A.</p>			<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">SEPTEMBER 20, 1971 4:10 P.M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">ST AGNES HOSPITAL</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY Baltimore</p> <p>C. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 318 Stone wall Rd</p>		
<p>5. SEX FEMALE</p>		<p>6. RACE WHITE</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>HOUSEWIFE</p>			<p>8. DATE OF BIRTH 06/9/88</p>		<p>9. AGE (In years last birthday) 83</p>
<p>10B. KIND OF BUSINESS OR INDUSTRY</p>			<p>11. BIRTHPLACE (State or foreign country) LITHUANIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? U S A</p>
<p>13. FATHER'S NAME</p> <p style="text-align: center;">(Unknown) Senkas</p>			<p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center;">Unknown</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;">No</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;">216036320</p>		<p>17. INFORMANT BALTIMORE MD 21229</p> <p>ST AGNES RECORDS WILKENS & CATON AVES</p>	
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction 4 days -</p> <p>(B) Arteriosclerotic heart disease - indeterminate</p> <p>(C) _____</p>					
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from <u>SEPTEMBER 16</u> 19 <u>71</u> to <u>SEPTEMBER 20</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>SEPTEMBER 20</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p style="text-align: center;"><i>Paulo Westphalen MD</i></p>				<p>23B. DATE SIGNED</p> <p style="text-align: center;"><u>9/20/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="text-align: center;">DR PAULO WESTPHALEN, M.D.</p>				<p>23D. ADDRESS</p> <p style="text-align: center;">BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVES</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center;">Burial</p>		<p>24B. DATE</p> <p style="text-align: center;">9-24-1971</p>		<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="text-align: center;">Holy Redeemer Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;">Baltimore, Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971</p>			
<p>25B. NAME OF REGISTRAR</p> <p style="text-align: center;">Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR</p> <p style="text-align: center;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-165 71 8928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 8928

BIRTH NO. 1

1. NAME OF DECEASED (Type or Print) TAYBRON, NAZEL V.

2. DATE AND HOUR OF DEATH 9-21-71 4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 1402

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD. GEN HOSP
827 LINDEN AVE
BALT. MD.

C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 1706 MADISON AVE.

5. SEX F 6. RACE N 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 3-10-25 9. AGE (In years last birthday) 46 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10B. KIND OF BUSINESS OR INDUSTRY HOME 11. BIRTHPLACE (State or foreign country) MD 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WALTER TAMPSON 14. MOTHER'S MAIDEN NAME UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT ALFONSO TAYBRON ADDRESS 1706 MADISON AVE

18. 430.9 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF:

(B) Extreme brain damage (Anoxic death)
DUE TO, OR AS A CONSEQUENCE OF:

(C) CVA - prob. rupture cerebral art. aneurysm

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR? —

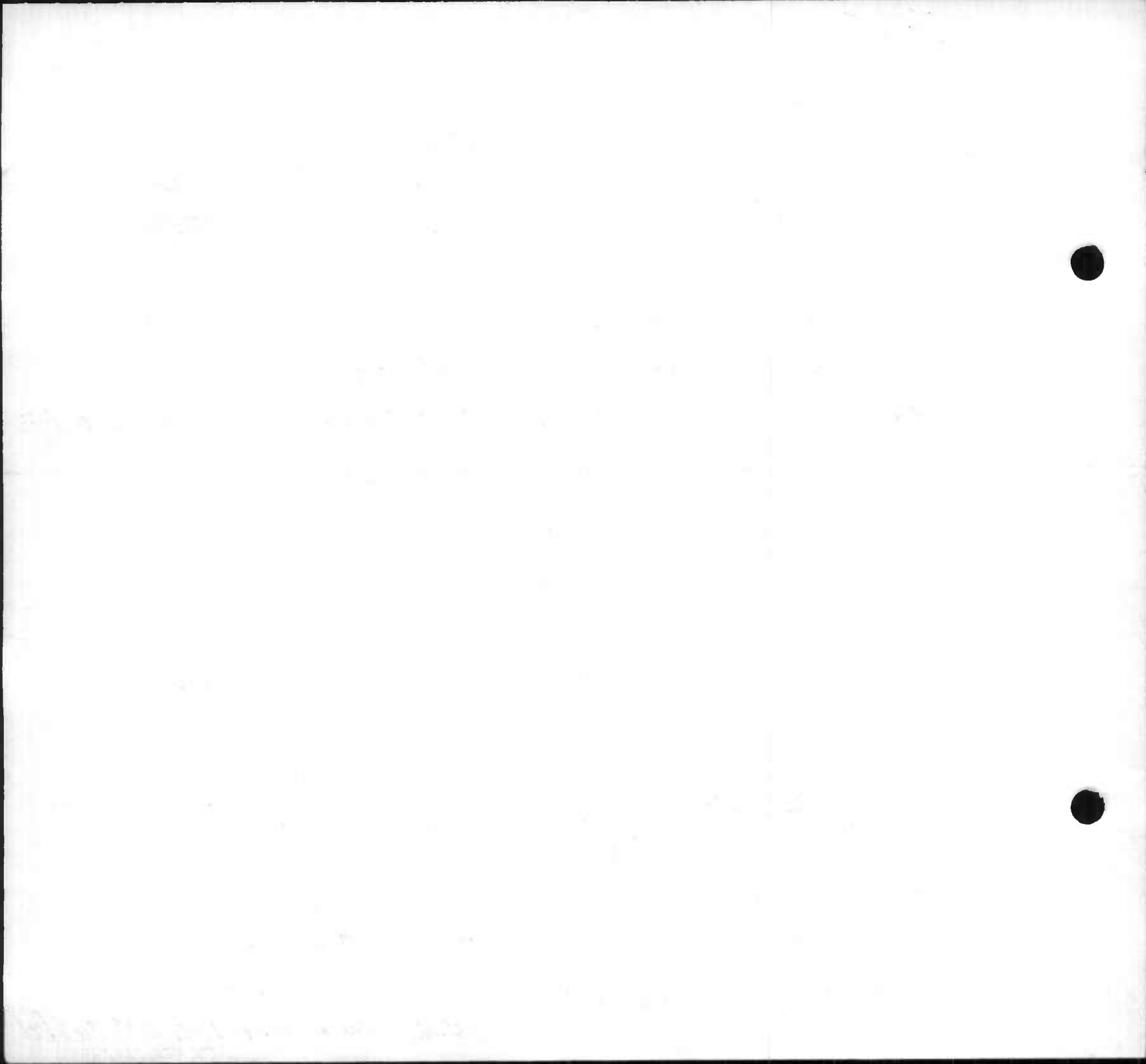
22. I certify that (I) (this hospital) attended the deceased from 9-18 19 71 to 9-21 19 71 that (I) (we) last saw the deceased alive on 9-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Arnold G. Alexander MD DEGREE MD Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 9-21-71

23C. PHYSICIAN'S NAME (Type) Arnold G. Alexander MD 23D. ADDRESS M.G. H. 827 Linden Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 9/22/71 24C. NAME OF CEMETERY OR CREMATORY Arbiter Mem. Pk. 24D. LOCATION (City, town, or county) (State) Balto. Md.

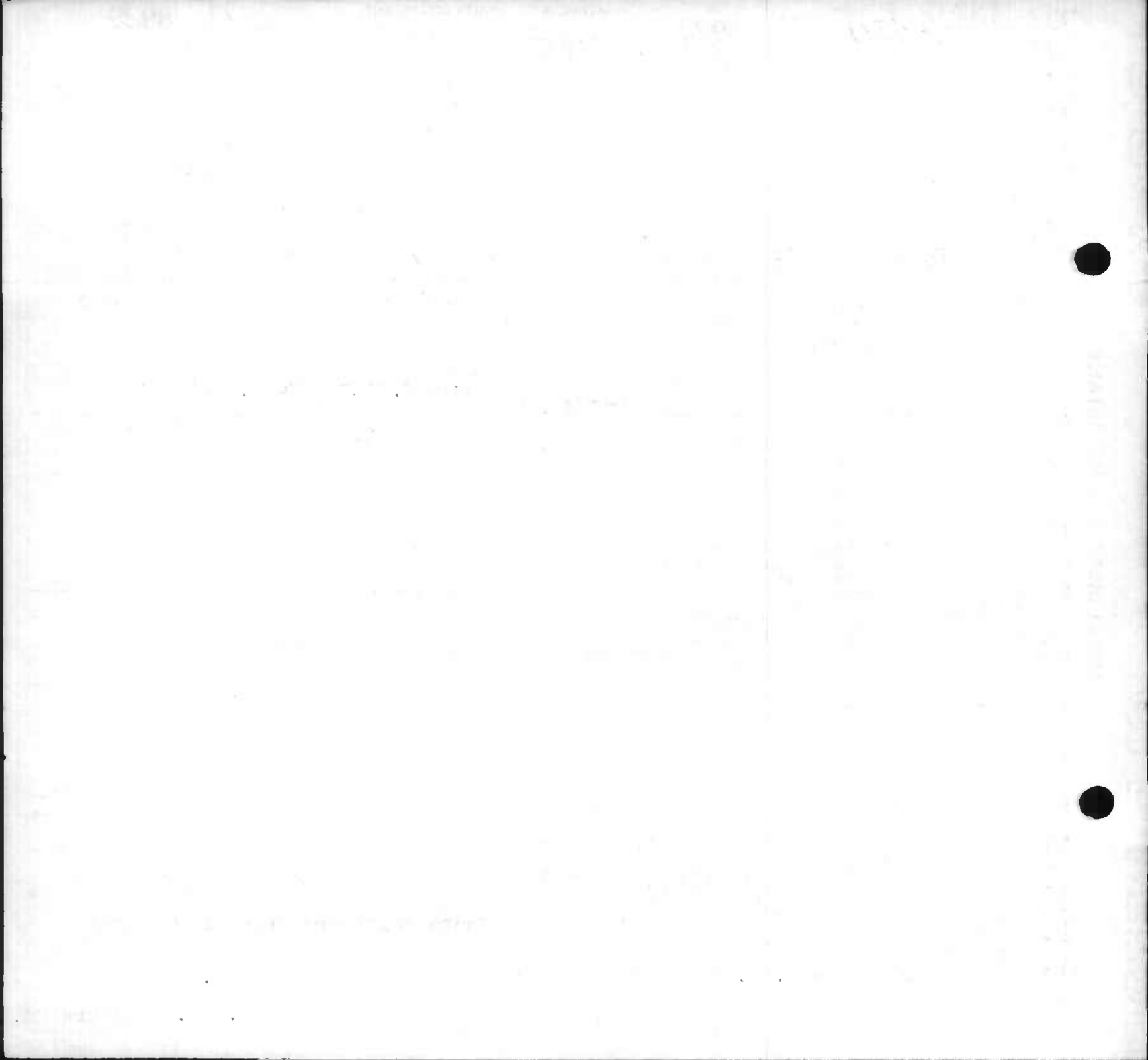
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971 25B. NAME OF REGISTRAR Robert E. J. ... 25C. FUNERAL DIRECTOR Chas. J. ... ADDRESS 1701 M. ...



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8929
R-530 71 8929 CERTIFICATE OF DEATH				REG. NO. 71 8929
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Mandy MANDI RINTA		Sept. 17, '71 6:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
South Baltimore General Hospital		Maryland Baltimore city 2605		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Housewife				10/12/1900 70
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)
Finland		FINLAND		70
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Kaile Tissari		?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		220-22-2662A		Hugo J. Rinta, 626 S. Quail St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Congestive Heart Failure				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from Sept. 16 19 71 to Sept. 17 19 71 that (X) (we) last saw the deceased alive on Sept. 17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Chin Sung Chan M.D. DEGREE				Sept. 17, '71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
		South Baltimore General Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		Sept. 20, 1971		Oak Lawn Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
SEP 24 1971		Robert E. Ranta, M.D.		HENRY SANDER & SONS, INC. Baltimore Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Vida M. Willey

2. DATE AND HOUR OF DEATH

9/20/71

12:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital

Dart City Hosp.

4940 Eastern Avenue, Balto. Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

8214 N. View Road 21222

5. SEX

Female

6. RACE

White

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9-19-04

9. AGE (in years)

67

If Under 1 Yr.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Eugene Mettee

14. MOTHER'S MAIDEN NAME

Agatha Weissner

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-44-4620

17. INFORMANT

BCH Records: 4940 Eastern Ave. Balto. Md

ADDRESS 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiopulmonary Arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Infarction

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 hr

6 hr

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

A.S.C.U.D.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

NO

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 10 AM 9/19 1971 to 12:15 AM 9/20 1971 that (1) (we) last saw the deceased alive on 9/20 12:15 PM 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dan Tartaglia MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

9/20/71

23C. PHYSICIAN'S NAME (Type)

DAN TARTAGLIA MD

23D. ADDRESS

B. C. H. 4940 Eastern Ave. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/23/71

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 24 1971

25B. NAME OF REGISTRAR

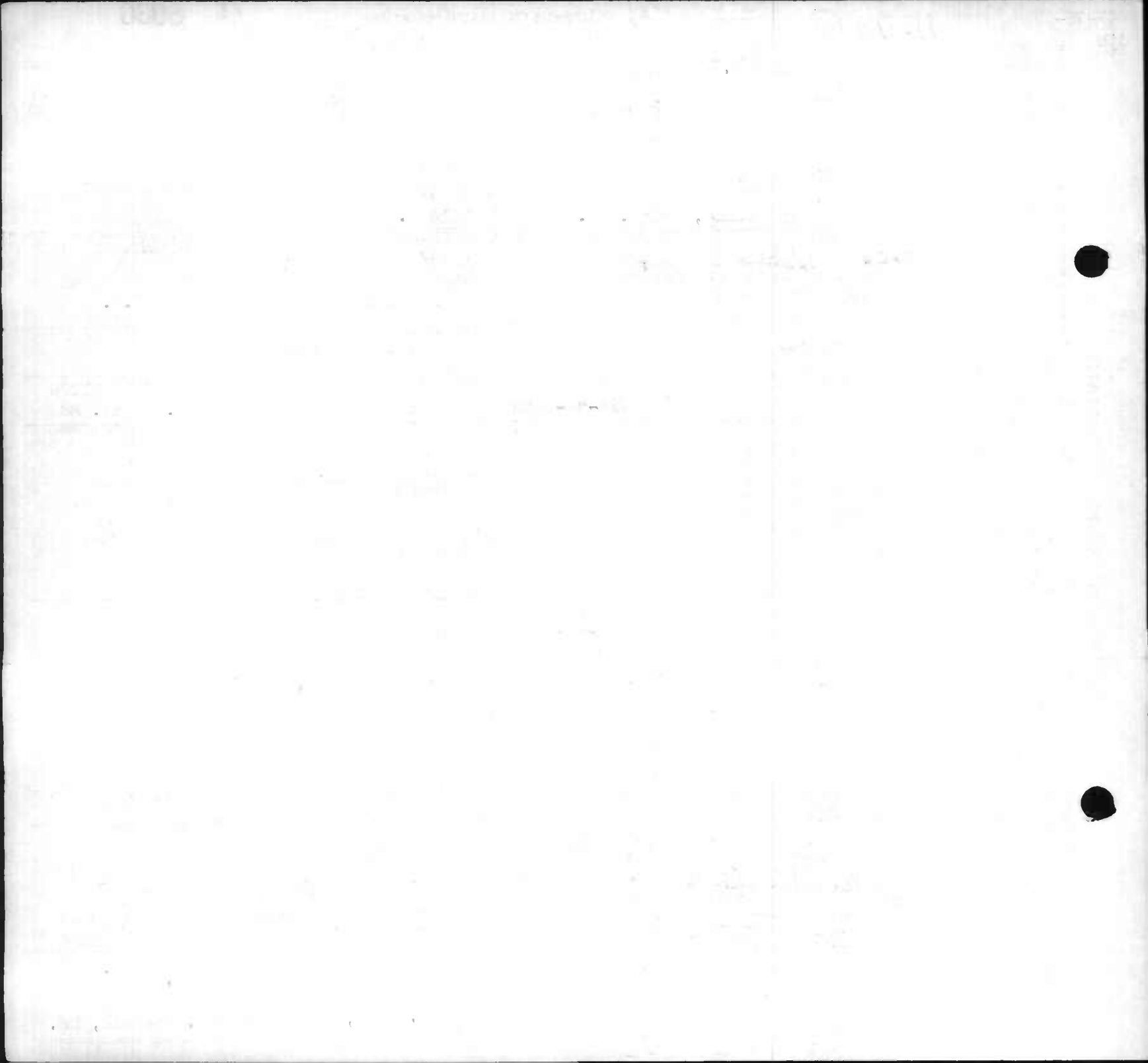
Robert E. G. 190.0

25C. FUNERAL DIRECTOR

John O. Duda

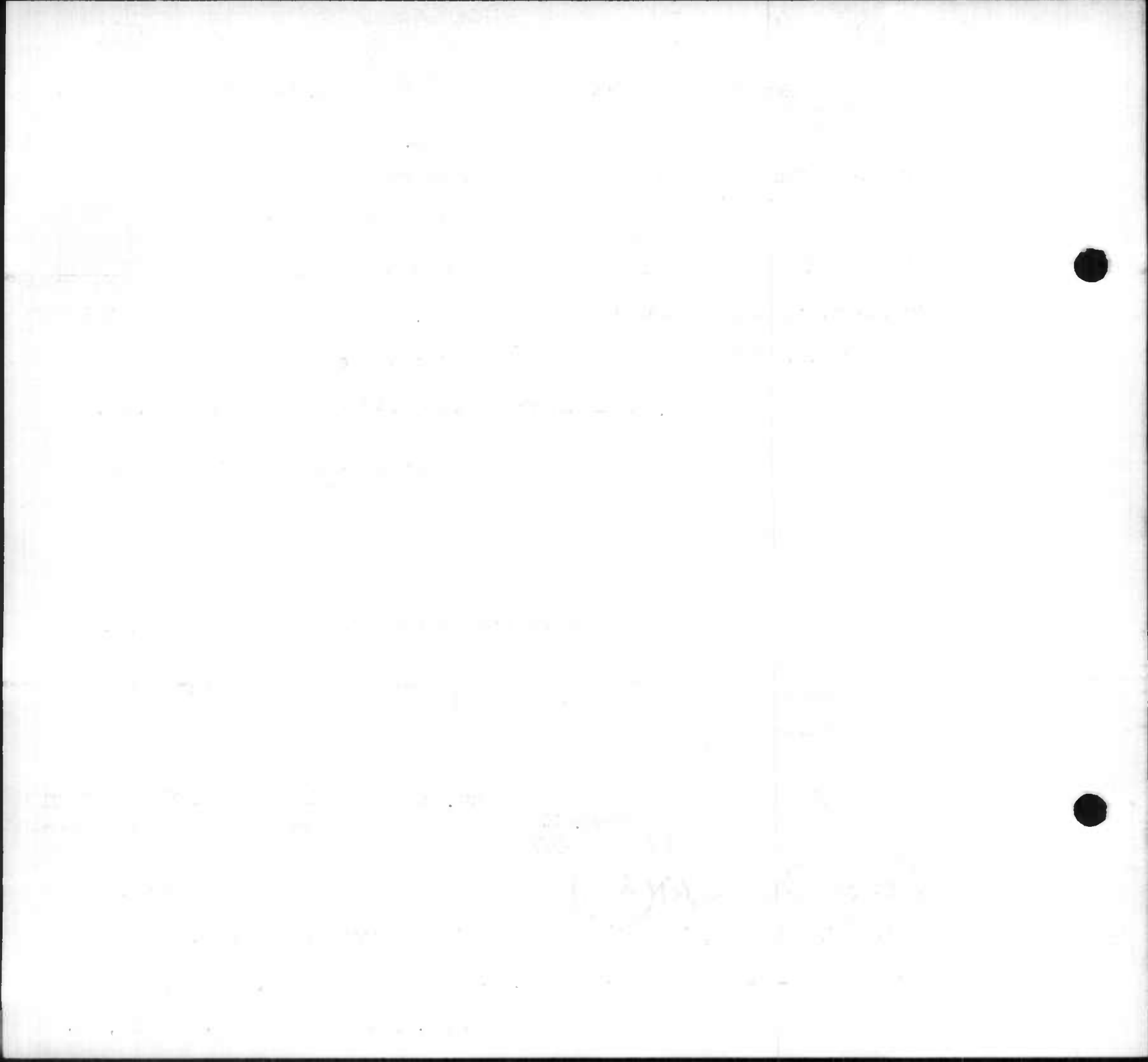
ADDRESS

7922 Wise Ave. Dundalk, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

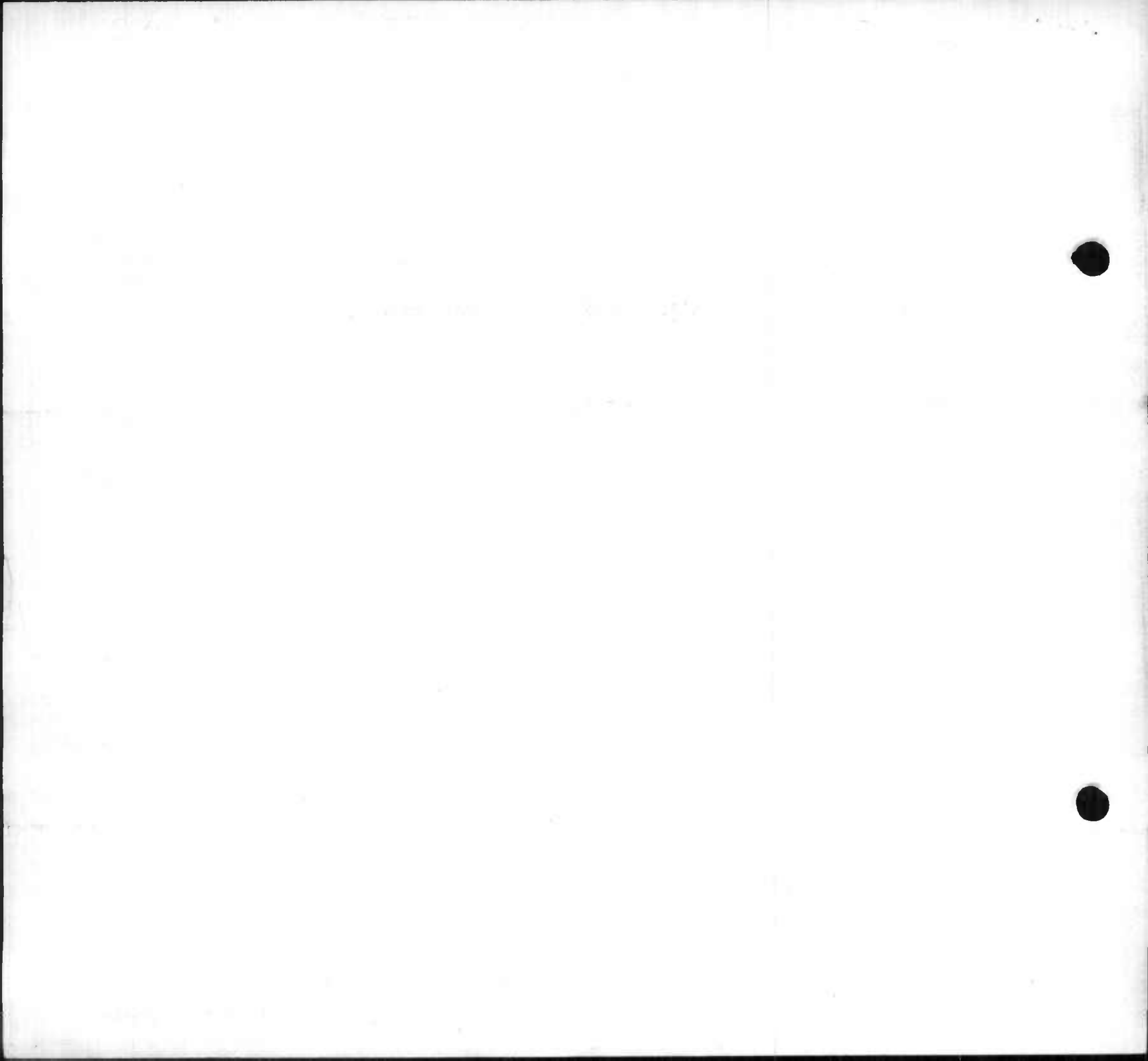
<p>B-100 71 8931</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8931</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Kenneth Leland Bobo</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>Sept. 21, 1971 5 A <small>M.</small></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>US Public Health Service Hospital 3100 Wyman Parkway</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY BALTO 5300</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3161 Baybriar Rd.</p>	
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 7/20/13</p>
<p>9. AGE (In years last birthday) 58</p>		<p>10. Under 1 Yr. Months: Days: Hours: Min.</p>	<p>11. Under 24 Hrs. Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Mechanical operator</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>Bethlehem Steel</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p>Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>USA</p>	
<p>13. FATHER'S NAME</p> <p>Thomas H.L. Bobo</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p>Rosa Shade</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No</p>		<p>16. SOCIAL SECURITY NO.</p> <p>217-05-4637</p>	<p>17. INFORMANT ADDRESS</p> <p>Records- US PHS Hospital, Balto, Md.</p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>Bilateral focal pneumonia</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>Right parieto-occipital astrocytoma</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>Days</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>1 yr.</p>			
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Aug. 21 19 71 to Sept. 21 19 71 that (I) (we) last saw the deceased alive on Sept. 21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p>Robert E. Belliveau, MD (Surg)</p>		<p>23B. DATE SIGNED</p> <p>9/21/71</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p>Robert E. Belliveau, Surg (R)</p>		<p>23D. ADDRESS</p> <p>US PHS Hospital, Balto, Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p>		<p>24B. DATE</p> <p>9-24-71</p>	<p>24C. NAME OF CEMETERY or CREMATORY</p> <p>Meadowridge Mem. Park</p>
<p>24D. LOCATION (City, town, or county) (State)</p> <p>Dorsey, Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>SEP 24 1971</p>	
<p>25B. NAME OF REGISTRAR</p> <p>John J. Duda</p>		<p>25C. FUNERAL DIRECTOR</p> <p>John J. Duda</p>	
<p>ADDRESS</p> <p>7922 Wise Ave. Dundalk, Md.</p>			



FUNERAL DIRECTOR: IMPORTANT

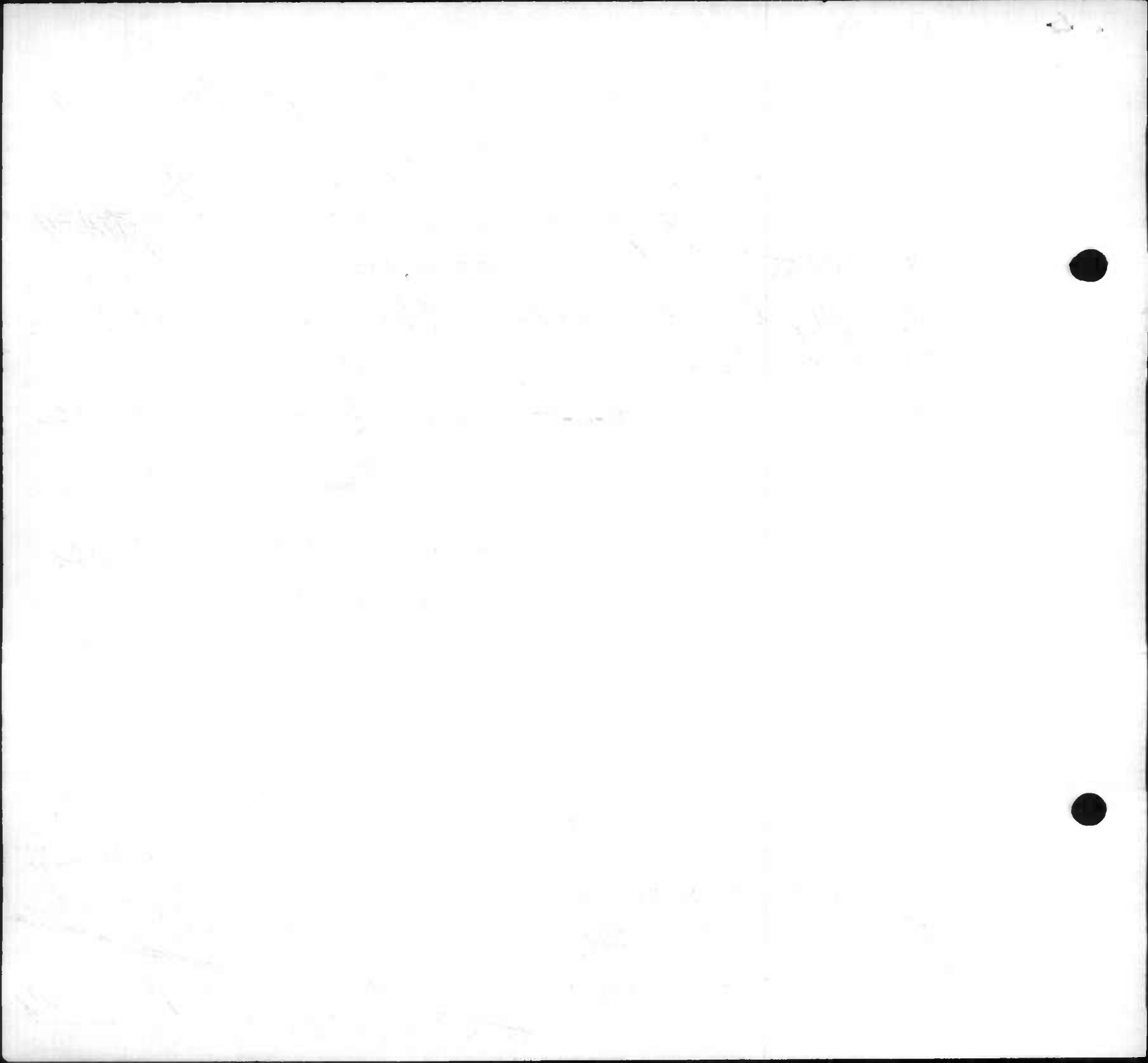
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8932
L-652 71 8932				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William Lawrence</u> last name		
2. DATE AND HOUR OF DEATH <u>9/20/71</u> 2 30 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Md. Hosp.</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2735</u>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. DATE OF BIRTH <u>9/11/04</u> 9. AGE (In years last birthday) <u>67</u>		E. STREET AND NUMBER <u>6803 Everall Ave.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto Transit Co</u>		
11. BIRTHPLACE (State or foreign country) <u>Texas Maryland</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>John Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Edna</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-10-0800</u>		17. INFORMANT <u>Mrs. Jessie Menninger</u> ADDRESS <u>Pt. + Daughter, 6803 Everall Ave.</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:				
(B) <u>Metastatic Bronchogenic Ca.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>4 mos</u>				
(C) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 yr</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>8/20/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bronchogenic Ca + Brain Metastases</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>9/17</u> 19 <u>71</u> to <u>9/20</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>R. W. Mellinger MD</u> DEGREE				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>R. W. Mellinger MD</u> DEGREE		23D. ADDRESS <u>Univ. of Md. Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-23-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>WALTER DABROWSKI</u> ADDRESS <u>1005 DUNDALK AVENUE</u>		



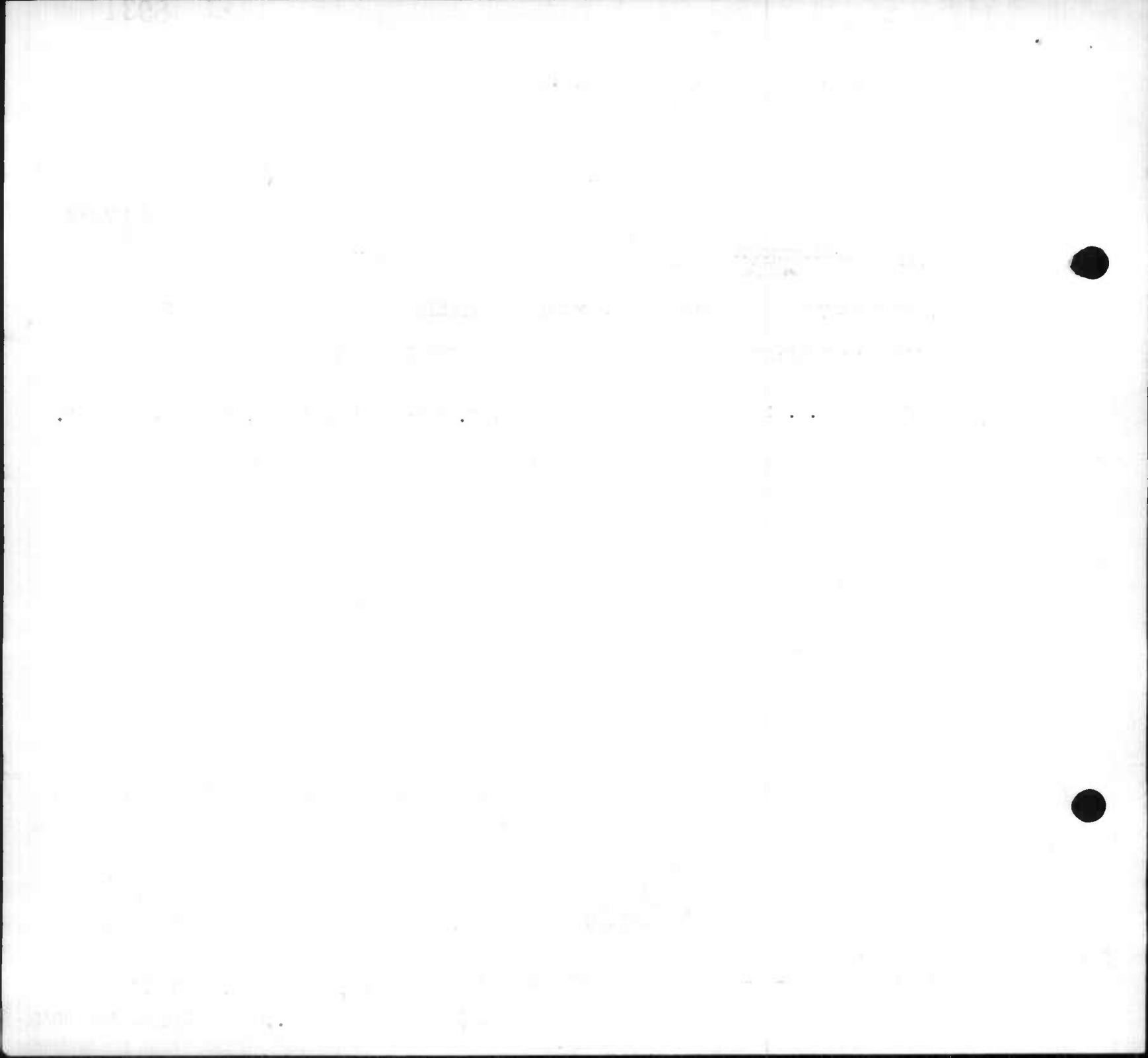
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-450 71 8933		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8933	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Solomon Willen		Sun Sept 19/71 9 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 2719	
3421 Glen Ave apt A-4		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3421 Glen Avenue - apt A-4					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 18, 1885	9. AGE (In years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Foods		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Rubin Willen		14. MOTHER'S MAIDEN NAME Medred?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-7779		17. INFORMANT Sarah Willen - 3421 Glen Ave	
18. CAUSE OF DEATH		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Dis Old myocardial infarct 10 yrs			
		(B) Arteriosclerosis Obliterans 3 years DUE TO, OR AS A CONSEQUENCE OF: night			
		(C) of leg - gangrene of legs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 55 to Sept 19 19 71 that (I) (we) last saw the deceased alive on 9/14/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. seen by Dr. M. M. Feldman Jr.					
23A. SIGNATURE Sol Smith		23B. DATE SIGNED 9/20/71			
23C. PHYSICIAN'S NAME (Type) MAURICE FELDMAN, JR		23D. ADDRESS 6810 Park Heights Ave			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 22/71		24C. NAME OF CEMETERY or CREMATORY Baal's Hebrew	
24D. LOCATION Baal's Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Feldman Jr.		25C. FUNERAL DIRECTOR Sol Feldman Jr. - 6010 Rustentown	



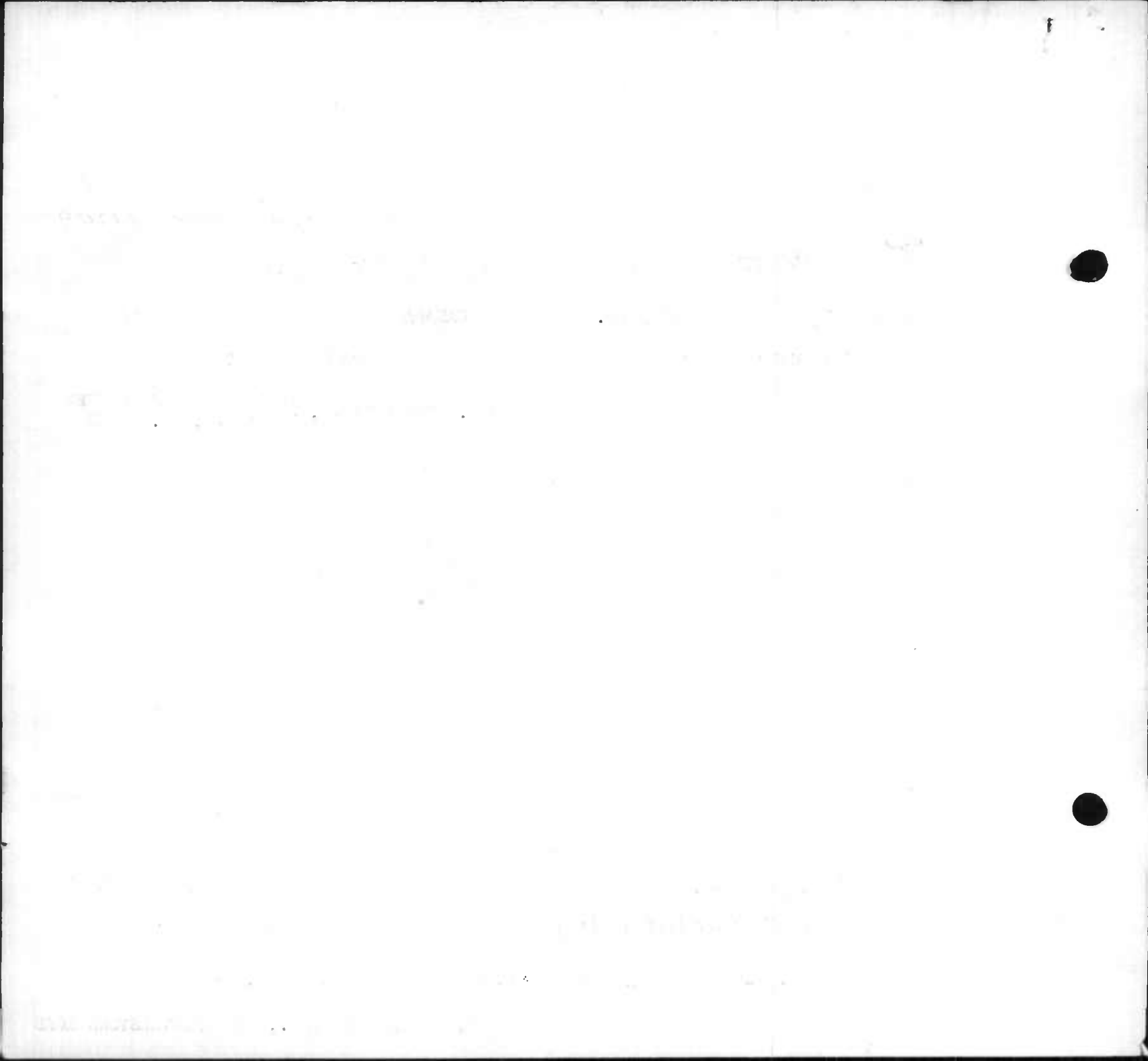
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 8934	
BIRTH NO. H-54271 8934					
1. NAME OF DECEASED (Type or Print) HIMMELSTEIN, JOSEPH		2. DATE AND HOUR OF DEATH 9/19/71 3 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore Inc.		A. STATE Maryland		B. COUNTY BALTO	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6821 Cherokee Dr. 21209					
5. SEX MALE	6. RACE BLACK WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1897	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY CLEANING & DYING		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JACOB HIMMELSTEIN		14. MOTHER'S MAIDEN NAME FANNIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ESTHER HIMMELSTEIN, 6821 CHEROKEE DR.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cardiac arrest.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute respiratory insufficiency			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic lung disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 4 19 71 to September 19 19 71 that (I) (we) last saw the deceased alive on September 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Z. Kalisky		23B. DATE SIGNED 9/19/71			
23C. PHYSICIAN'S NAME (Type) Dr. ZVI KALISKY		23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-22-71		24C. NAME of CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Talbot, M.D.		25C. FUNERAL DIRECTOR SOI LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

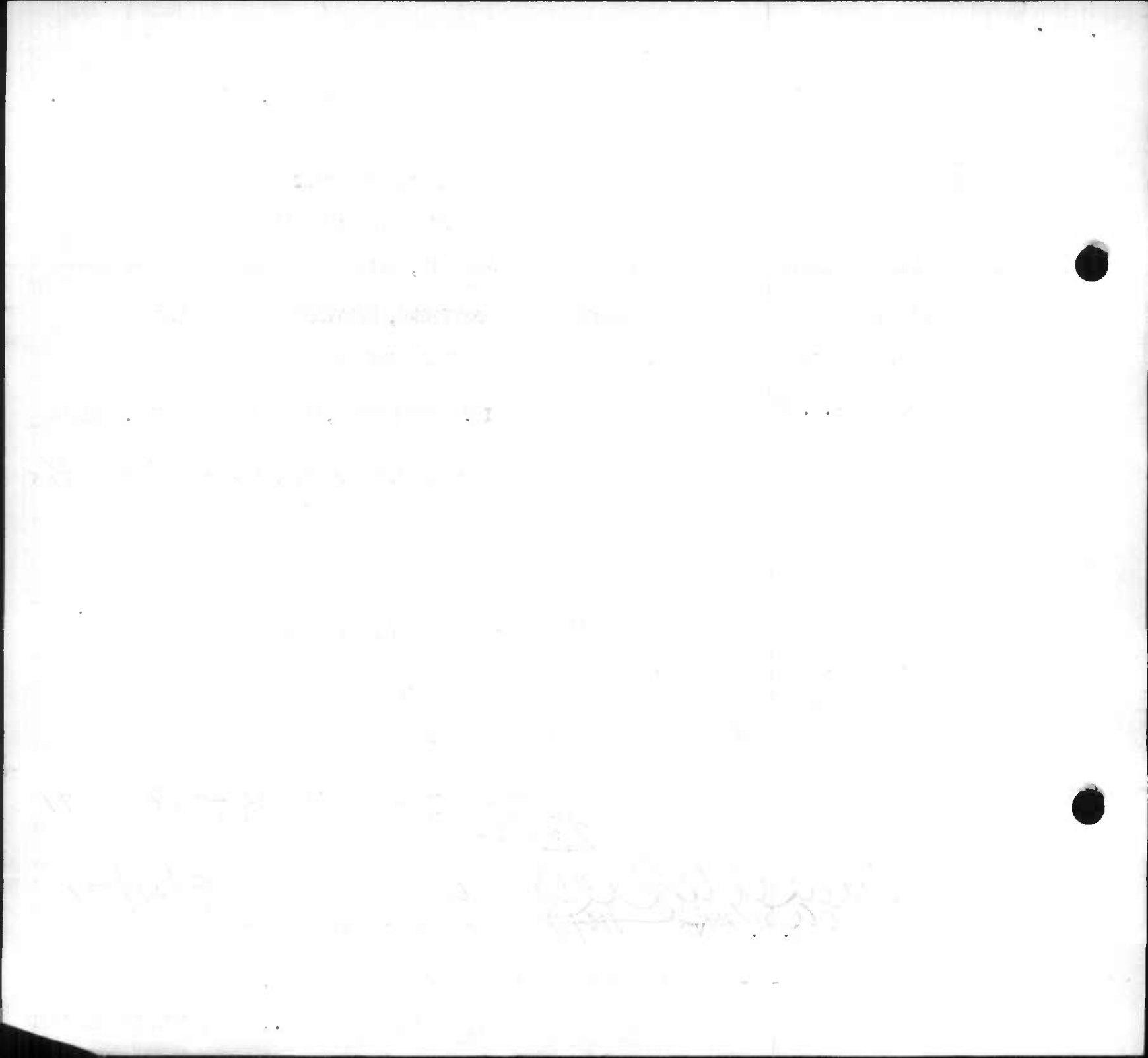
BALTIMORE CITY HEALTH DEPARTMENT				71 8935	
CERTIFICATE OF DEATH				REG. NO. 71 8935	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. S-432 71 8935</p> <p>1. NAME OF DECEASED (Type or Print) SELTZER, FANNYE</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 9/20/71 10:11 P.M.</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2730</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 3014 Fallstaff Manor 21209</p>		
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 3/20/1915</p>	<p>9. AGE (In years last birthday) 56</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady</p>			<p>10B. KIND OF BUSINESS OR INDUSTRY HECHT CO.</p>		<p>11. BIRTHPLACE (State or foreign country) CANADA</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>			<p>13. FATHER'S NAME HARRY SHAFFER</p>		
<p>14. MOTHER'S MAIDEN NAME RACHEL ?</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		
<p>16. SOCIAL SECURITY NO.</p>			<p>17. INFORMANT MRS. AUDREY FREED ADDRESS 12616 GRACE MAX STREET ROCKVILLE, MD. 20853</p>		
<p>18. CAUSE OF DEATH</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute M.I.</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiogenic shock Cardiopulmonary arrest</p> <p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 9/15/71 to 9/20/71 that (I) (we) last saw the deceased alive on 9/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>					
<p>23A. SIGNATURE K. Michopoulos M.D.</p>				<p>23B. DATE SIGNED 9/20/71</p>	
<p>23C. PHYSICIAN'S NAME (Type) K. Michopoulos M.D.</p>				<p>23D. ADDRESS Sinai Hospital</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 9-22-71</p>		<p>24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)</p>	
<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>		<p>25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971</p>			
<p>25B. NAME OF REGISTRAR Robert E. Bailey, Jr.</p>		<p>25C. FUNERAL DIRECTOR 501 LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>			



FUNERAL DIRECTOR: IMPORTANT

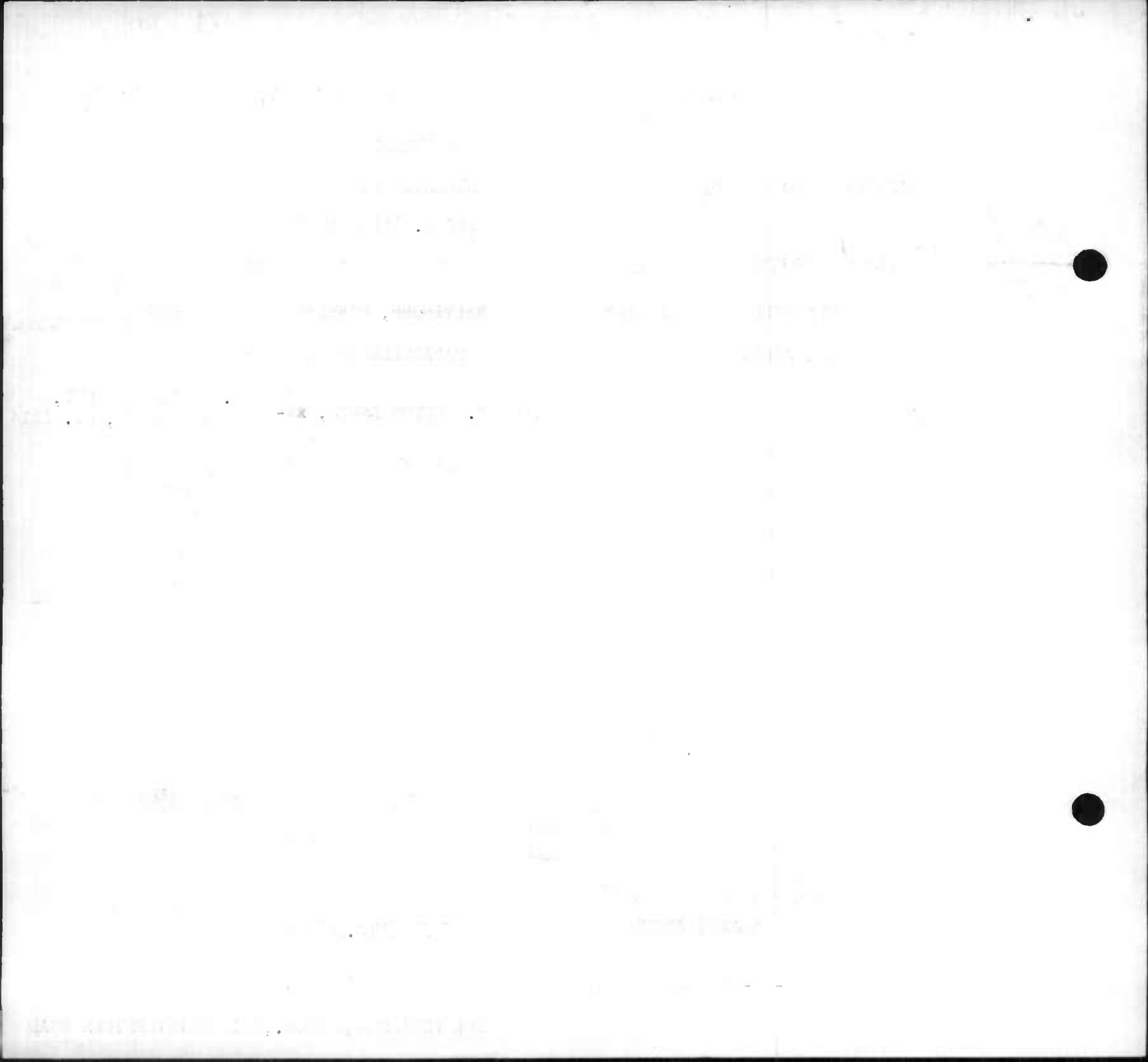
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-320 71 8936		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8936	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) HARRY KADISH			2. DATE AND HOUR OF DEATH SEPTEMBER 19, 1971 9 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5348 LANTERN COURT			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2854 C. CITY OR TOWN BALTIMORE #21229 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5348 LANTERN COURT		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1911	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME SAMUEL KADISH			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY			16. SOCIAL SECURITY NO.		
17. INFORMANT MISS RUTH KADISH, 4112 GROVELAND AVE. #21215			ADDRESS		
18. 157.9 14250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Pancreas ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mell. Ins.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 months (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 8 1971 to Sept 18 1971 that (I) (we) last saw the deceased alive on Sept 15 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE A. A. Silver				23B. DATE SIGNED 9/21/71	
23C. PHYSICIAN'S NAME (Type) A. A. SILVER		23D. ADDRESS 6210 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-22-71		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SPL LEVINSON & BROS., 6010 REISTERSTOWN RD			



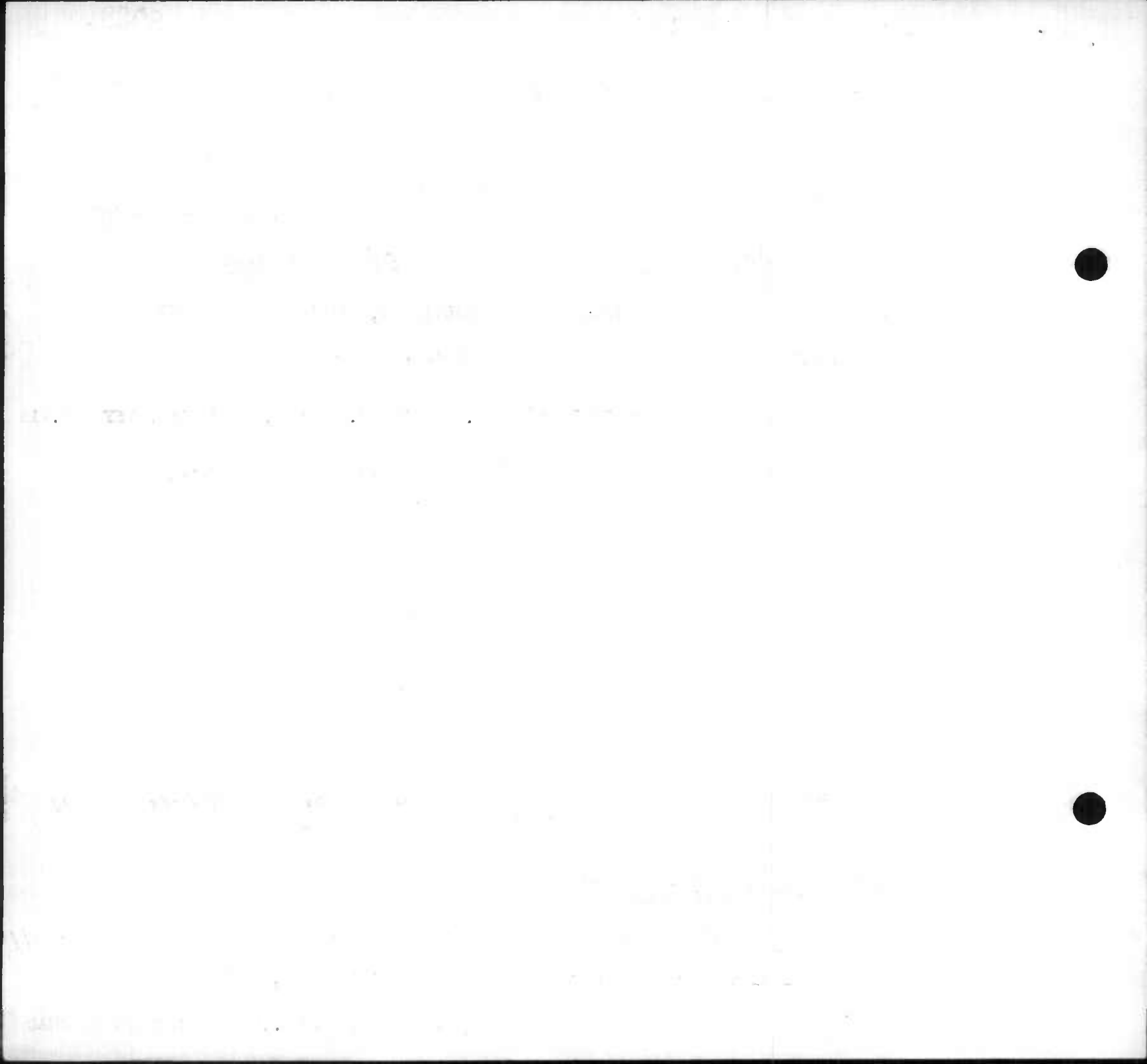
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635 71 8937		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8937	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ETTA GORDON		SEPTEMBER 21, 1971		12 NOON M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
EDGEWOOD NURSING HOME		NEW JERSEY			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		ATLANTIC CITY		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		117 S. ILLINOIS AVENUE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE On years (last birthday)	10. Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		75	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
FRANK ASKIN		SARABELLE BERMAN		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NO		4000 N. CHARLES STREET, HIGHFIELD HOUSE, APT. 1214	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Carcinoma of the lung			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/15/71 19 to 9/21/71 19 that (I) (we) last saw the deceased alive on 9/20/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
DEGREE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		9/21/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SAMUEL LEGUM		MEDICAL ARTS BUILDING			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		9-23-71		BNAI ISRAEL	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
BALTIMORE, MARYLAND		SEP 24 1971			
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		ADDRESS	
SOL. LEVINSON & BROS.		6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

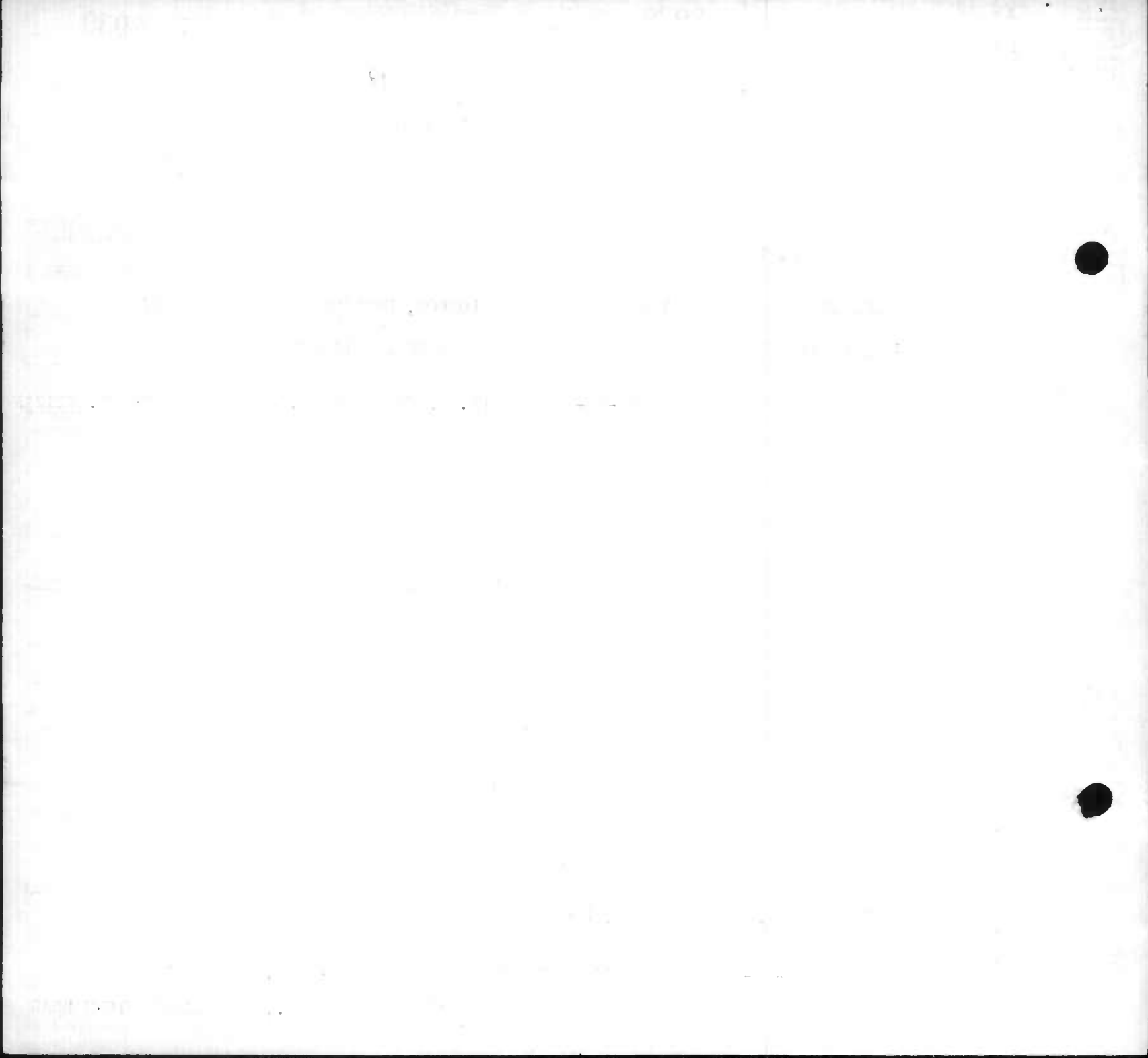
S-550 71 8938		BALTIMORE CITY HEALTH DEPARTMENT		71 8938	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) AUGUSTA E. SIMON			2. DATE AND HOUR OF DEATH 9/21/71 8 15 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hosp. of Balt., Inc.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. CITY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4004 ROSECREST AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/06	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10B. KIND OF BUSINESS OR INDUSTRY PIANO		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME MOSES ENTON			14. MOTHER'S MAIDEN NAME ANNIE FLORENCE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-34-1058A		17. INFORMANT ADDRESS MRS. AUGUSTA H. ALBERT, 4004 ROSECREST AVE. #15	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Infarction (massive) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Heart Disease with Atrial Fibrillation			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8/24 19 71 to 9/21 19 71 that (H) (we) last saw the deceased alive on 9/21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jan Sunshine M.D.			23B. DATE SIGNED 9/21/71		23C. PHYSICIAN'S NAME (Type) IAN SUNSHINE M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 9-22-71		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		
25B. NAME OF REGISTRAR B. E. Baker, M.D.			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

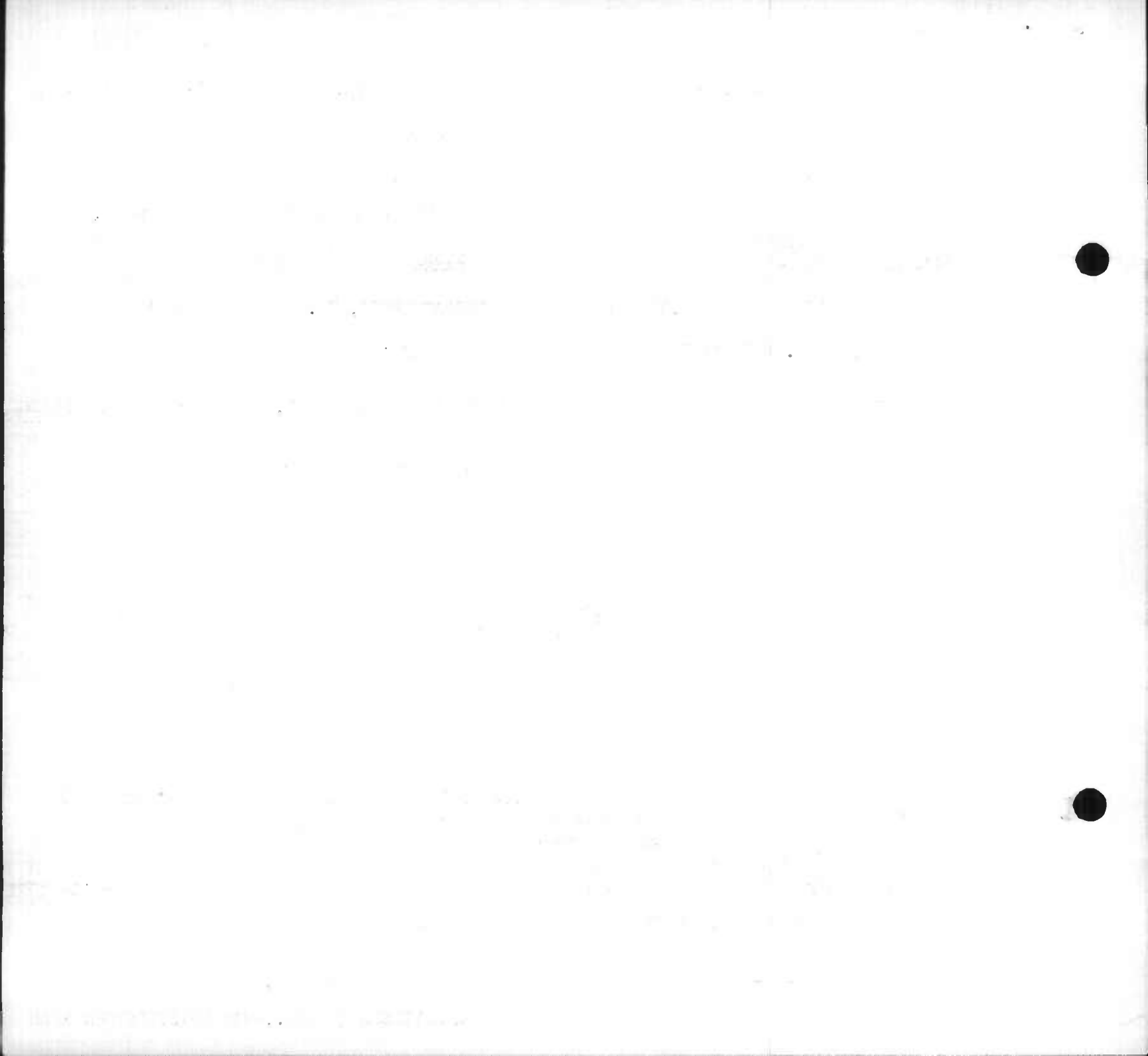
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8939	
H-620 71 8939				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BETTY HARRIS		2. DATE AND HOUR OF DEATH 9/20/71 12:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2831		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO.			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 4226 Labyrinth		
5. SEX <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/04	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LONDON, ENGLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JULIUS GALINSKY		14. MOTHER'S MAIDEN NAME RACHEL GALINSKY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-18-6909A		17. INFORMANT ADDRESS MRS. BERNARD GELMAN, 4226 LABYRINTH RD. #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute MI DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 9/11/71 19 9/20/71 19 that it (we) last saw the deceased alive on 9/20 19 71 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fortunato V. Elizaga M.D. DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) FORTUNATO V. ELIZAGA DEGREE				23D. ADDRESS SINAI HOSP. OF BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-22-71		24C. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Haden, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

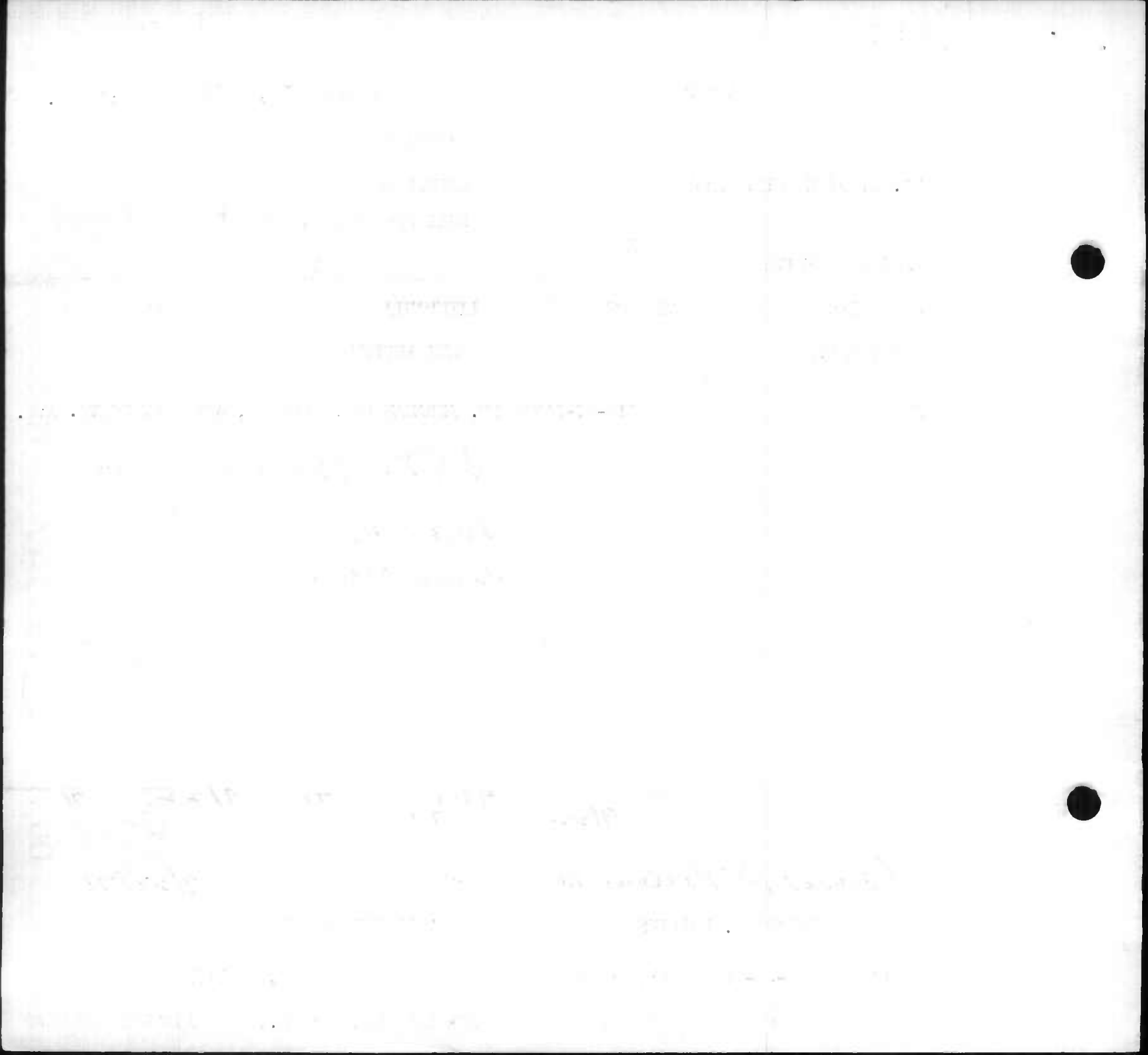
L-150		71 8940		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8940	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
DELLA LEVIN				September 22, 1971 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
LEVINDALE				MARYLAND 1301			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		PHILADELPHIA, PA.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ABRAHAM M. GOLDSTONE				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						LEVINDALE HEBREW HOME, BELVEDERE & GREENSPRING AVE	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				WEEKS			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				BILATERAL PNEUMONIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ARTERIOLE Nephrosclerosis			
				PULMONARY EDEMA			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from August 4 1956 to September 22 1971 that (X) (we) last saw the deceased alive on September 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
THEODORE R. REIFF, M.D.				September 23, 1971			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LEVINDALE							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9-23-71		HEBREW FRIENDSHIP		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 24 1971		Robert E. Taylor, Jr.		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

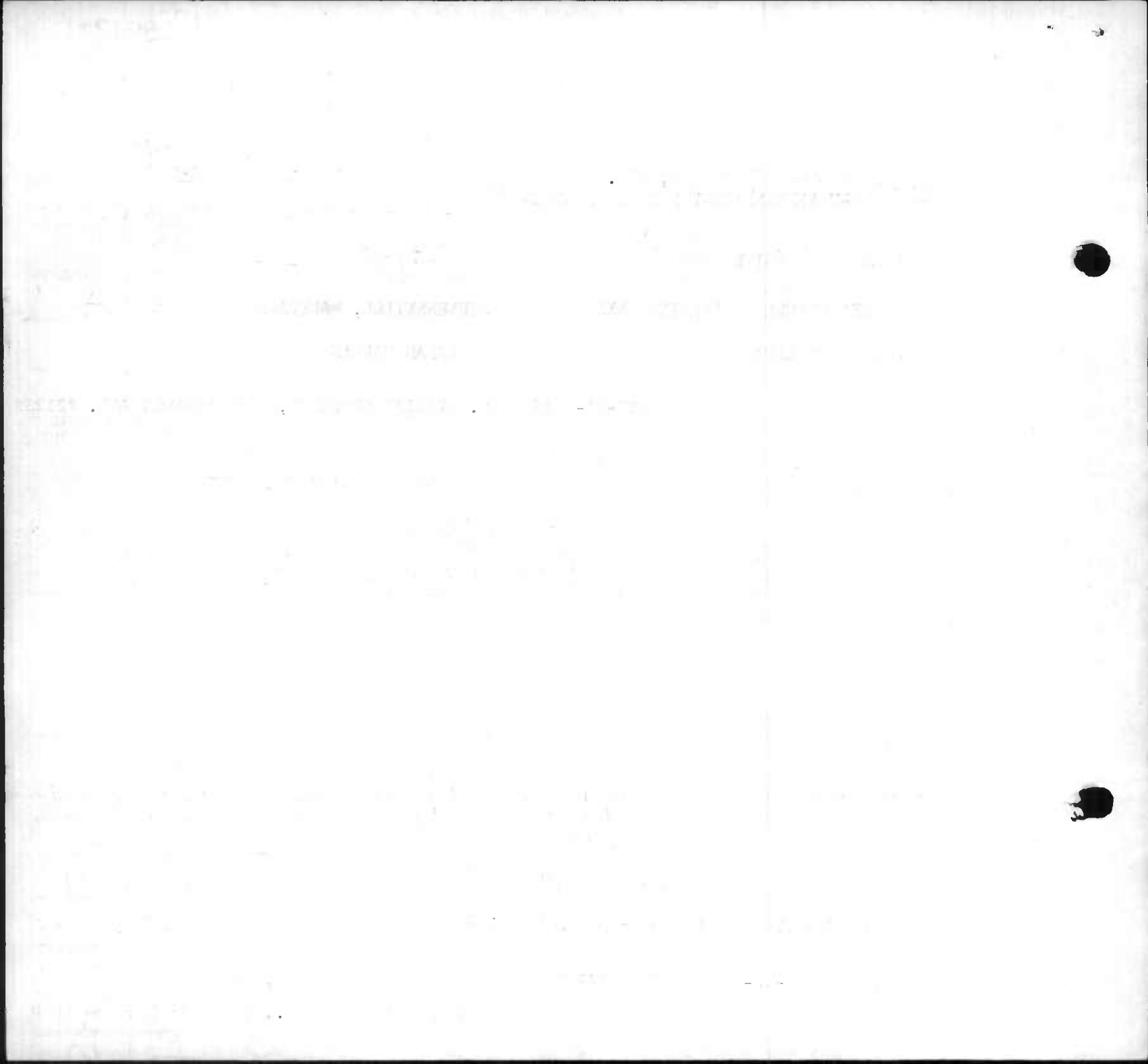
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8941</u>	
BIRTH NO. <u>P-626 71 8941</u>					
1. NAME OF DECEASED (Type or Print) <u>ELSIE PROUSER</u>			2. DATE AND HOUR OF DEATH <u>SEPTEMBER 22, 1971</u> <u>2:55 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MT. SINAI NURSING HOME</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>5421 PARK HEIGHTS AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>ISAAC LEVIN</u>			14. MOTHER'S MAIDEN NAME <u>ANNA LEVITT</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-5373B</u>		17. INFORMANT <u>MR. ABRAHAM PAUL PROUSER, 5421 PARK HIGHTS. AVE.</u>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>(A) IMMEDIATE CAUSE <u>Intestinal Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>Cardiac Arrest</u></p> </div> <div style="width: 5%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u></p> </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9/22/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>71</u> to <u>9/22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward S. Kallins M.D.</u>			23B. DATE SIGNED <u>9/23/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>EDWARD S. KALLINS</u>			23D. ADDRESS <u>6000 PARK HEIGHTS AVENUE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-23-71</u>		24C. NAME of CEMETERY or CREMATORY <u>AITZ CHAIM</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8942	
<div style="display: flex; justify-content: space-between;"> G-645 71 8942 71 8942 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) SYLVAN GROLLMAN </div> <div> 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <div>9/21/71</div> <div>5 P. M.</div> </div> </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="font-size: 1.2em;">5606 WOODMONT AVENUE, APT. B</div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div>A. STATE Md</div> <div>B. COUNTY 2748</div> </div>		
5. SEX <div style="display: flex; justify-content: space-between;"> <div>MALE</div> <div>RACE WHITE</div> </div>			6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <div style="display: flex; justify-content: space-between;"> <div>WIDOWED <input type="checkbox"/></div> <div>DIVORCED <input type="checkbox"/></div> </div>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">XXX FARMER</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em;">FARMING XXX</div>		8. DATE OF BIRTH <div style="font-size: 1.2em;">8/24/05</div>	
11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">STEVENSVILLE, MARYLAND</div>		9. AGE (In years last birthday) <div style="font-size: 1.2em;">66</div>		12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em;">USA</div>	
13. FATHER'S NAME <div style="font-size: 1.2em;">JOSEPH GROLLMAN</div>			14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">SARAH HARRIS</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em;">NO</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">217-36-4816</div>		17. INFORMANT ADDRESS <div style="font-size: 1.2em;">MRS. LILLIAN GROLLMAN, 5606 WOODMONT AVE. #21239</div>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> CAUSE OF DEATH <div style="font-size: 1.2em;">CARDIORESPIRATORY</div> <div style="font-size: 1.2em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARREST</div> <div style="font-size: 1.2em;">(B) AS VCD & CORONARY DUE TO, OR AS A CONSEQUENCE OF: INSUFFICIENCY</div> <div style="font-size: 1.2em;">(C) LYMPHOSARCOMA, SUSPECTED</div> </div> <div style="width: 45%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">3 weeks</div> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <div style="font-size: 1.2em;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED <div style="display: flex; justify-content: space-between;"> <div>While At Work <input type="checkbox"/></div> <div>Not While At Work <input type="checkbox"/></div> </div>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/14/71 to 9/21/71 and that (I) (we) last saw the deceased alive on 9/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="font-size: 1.2em;">P. Papastamou, M.D.</div>				23B. DATE SIGNED <div style="font-size: 1.2em;">9/21/71</div>	
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">P. PAPASTAMOU, MD</div>				23D. ADDRESS <div style="font-size: 1.2em;">6804 PARK HEIGHTS AVE.</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">BURIAL</div>		24B. DATE <div style="font-size: 1.2em;">9-23-71</div>		24C. NAME of CEMETERY or CREMATORY <div style="font-size: 1.2em;">ANSHE EMUNAH</div>	
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">BALTIMORE, MARYLAND</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">SEP 24 1971</div>			
25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">Sol Levinson & Bros.</div>		25C. FUNERAL DIRECTOR ADDRESS <div style="font-size: 1.2em;">6010 REISTERSTOWN ROAD</div>			



1
0-540

71 8943

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

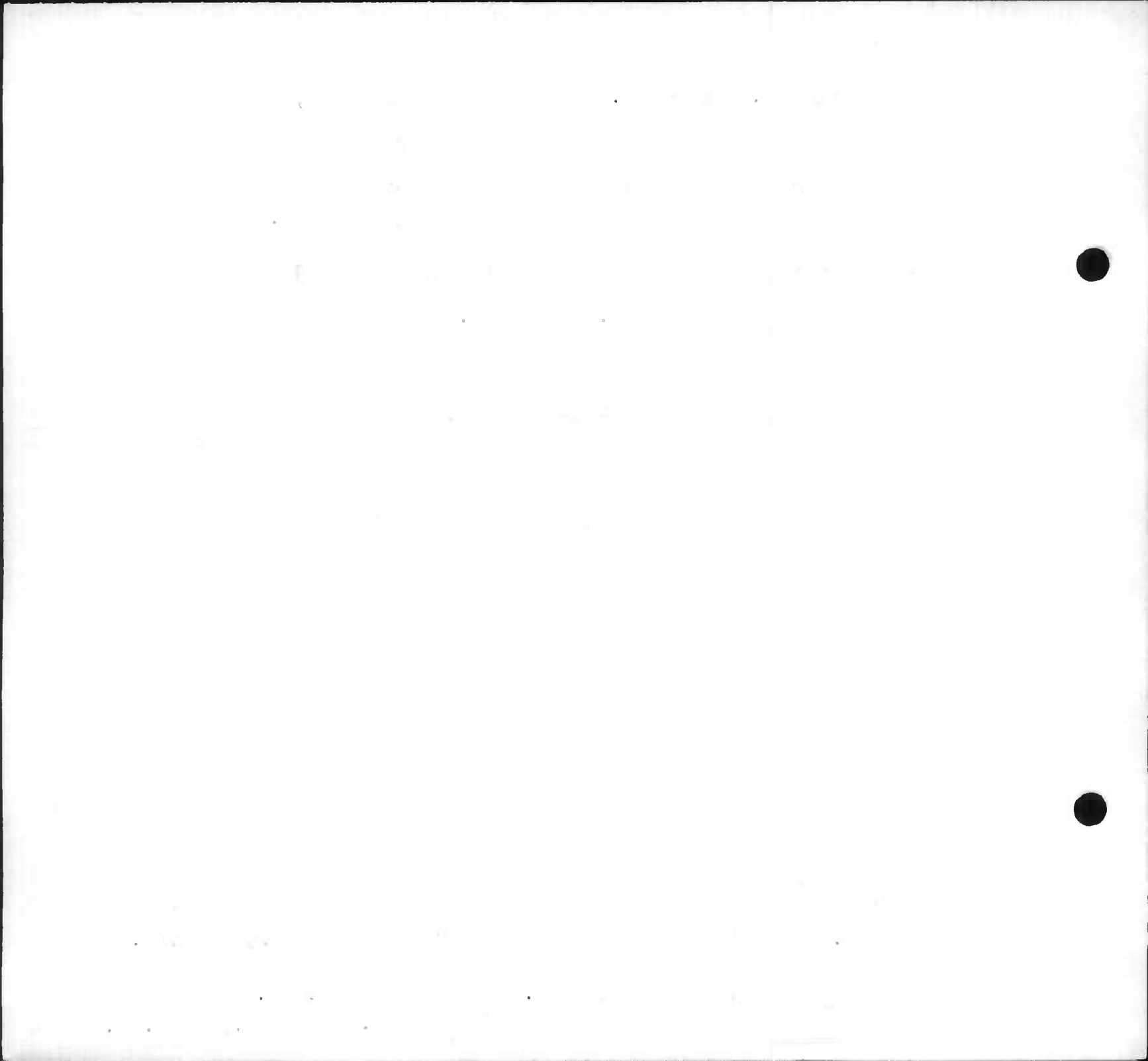
REG. NO. 71 8943

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PRESTON O'NEAL JR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month September Day 22 Year 1971 Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month September Day 22 Year 1971 Hour 7:00 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
9. DATE OF BIRTH MAR 1, 1910		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Preston O'neal Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction LABORER	
15. MOTHER'S MAIDEN NAME NEDDIE WHITNEY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 246-12-5		18. INFORMANT MABLE O'NEAL	
19. 442X		ADDRESS 1374 STOCKTON ST	
CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic pulmonary emphysema			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED September 22, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/25/71	
24C. NAME OF CEMETERY or CREMATORY MT AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. BROOKS		ADDRESS Ringgold 1463 N. CAREY ST	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

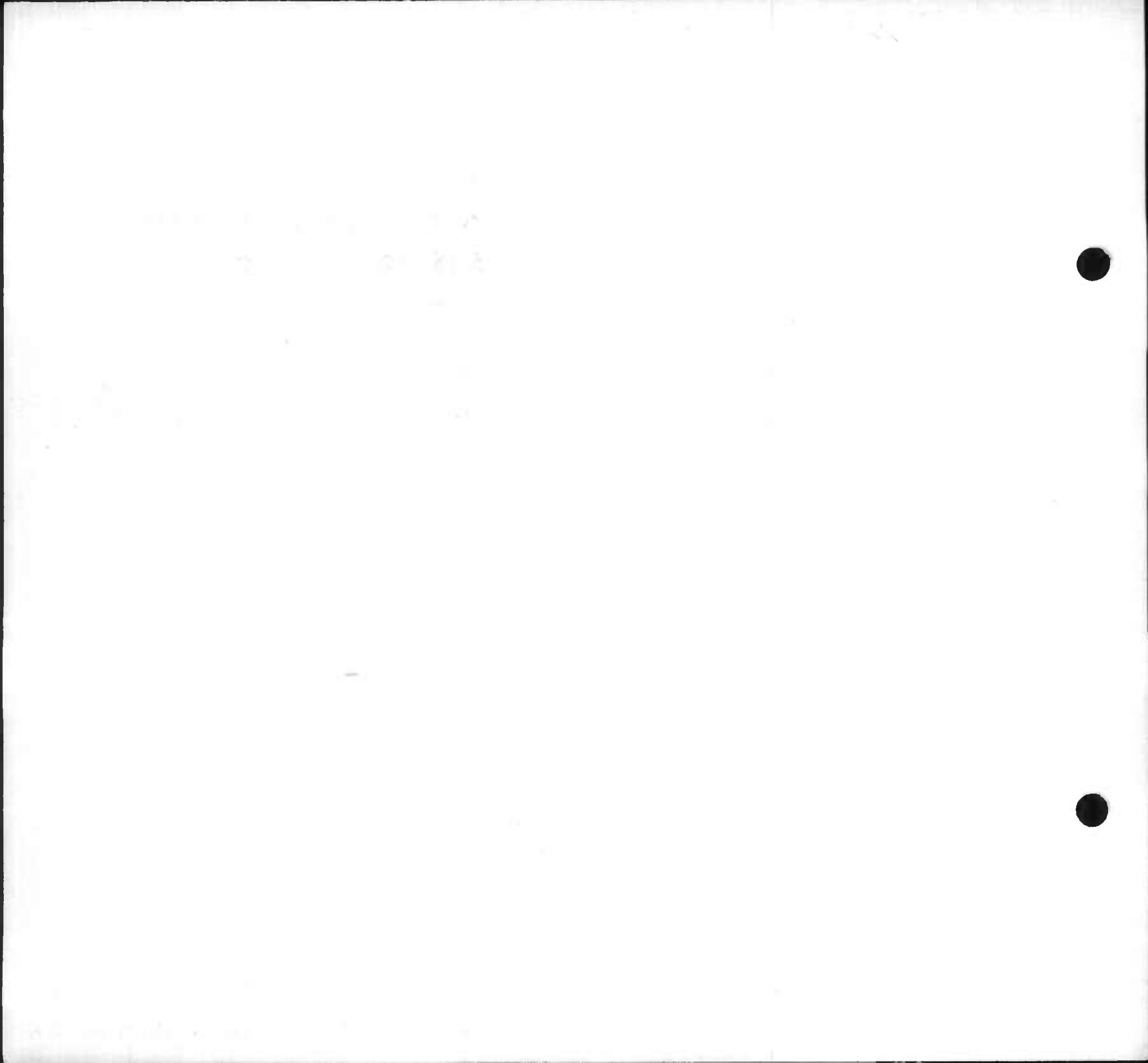
L-230 71 8944		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8944	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James P. Leicht Jr.		Sept 21, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Maryland		2739	
Union Memorial Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
44		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1358 Winston Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/25/1909	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales		Hecht Co.		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Leicht		Maggie Hart		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes WW 2		213-09-8380		Mrs. Catherine Leicht same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE		Few minutes	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		15 years	
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1956 to Sept. 1971 that (I) (we) last saw the deceased alive on Sept. 16, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. Loy Zimmerman		9/21/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Loy Zimmerman		3202 Harford Rd., Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9/25/71		Moreland Mem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 24 1971		Leonard J. Ruck Inc.		21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-162 71 8945		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8945	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) ADA RIVERS			2. DATE AND HOUR OF DEATH Sept 22, 1971 5:35A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1502		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL, 730 ASHBURTON ST. BALTIMORE, MD 21216.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3-18-1901		9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Isaac Caine			14. MOTHER'S MAIDEN NAME Sarena		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mildred Carter 1613 N. APPLETON ST. (DAUGHTER)	
18. 436.01 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRO-VASCULAR-ACCIDENT			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: 4 days		
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/18/1971 to 9/22/1971 that (I) (we) last saw the deceased alive on 9/22/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Azad Cader			23B. DATE SIGNED Sept 22, 1971		
23C. PHYSICIAN'S NAME (Type) AZAD CADER			23D. ADDRESS Lutheran Hosp, Baltimore, Md 21216.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-71		24C. NAME OF CEMETERY or CREMATORY Union Cypress Cem.	
24D. LOCATION Gordon, South Carolina		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Md.		25C. FUNERAL DIRECTOR Charles A. Rice	
				ADDRESS 661 W. Barre St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-160 71 8946				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8946	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>John Joseph E Ber</i>				2. DATE AND HOUR OF DEATH <i>9-23-71 8:15 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2123 McHenry St</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2005</i>			
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Sept 27-1898</i>		9. AGE (In years last birthday) <i>72</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO MD</i>	
13. FATHER'S NAME <i>Charles</i>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-03-0530</i>		17. INFORMANT <i>Agnes Douglas 2123 McHenry St</i>	
18. I <i>72</i> <i>9</i> <i>I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>9-23-71</i>				CAUSE OF DEATH <i>Heart arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic congestive heart failure with valvular disease</i> (B) Tumor of rt lung. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>Sept. 23, 1971</i> , that (I) (we) last saw the deceased alive on <i>Sept. 23, 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley Ankudas</i> DEGREE						23B. DATE SIGNED <i>9.24.71</i>	
23C. PHYSICIAN'S NAME (Type) <i>STANLEY ANKUDAS, M. D.</i>						23D. ADDRESS <i>1101 MAIDEN CHOICE LANE</i> DEGREE	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial 9-27-71</i>				24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO City</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1971</i>				25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Geo. P. Schmitt</i> ADDRESS <i>2101 Frederick Ave</i>	

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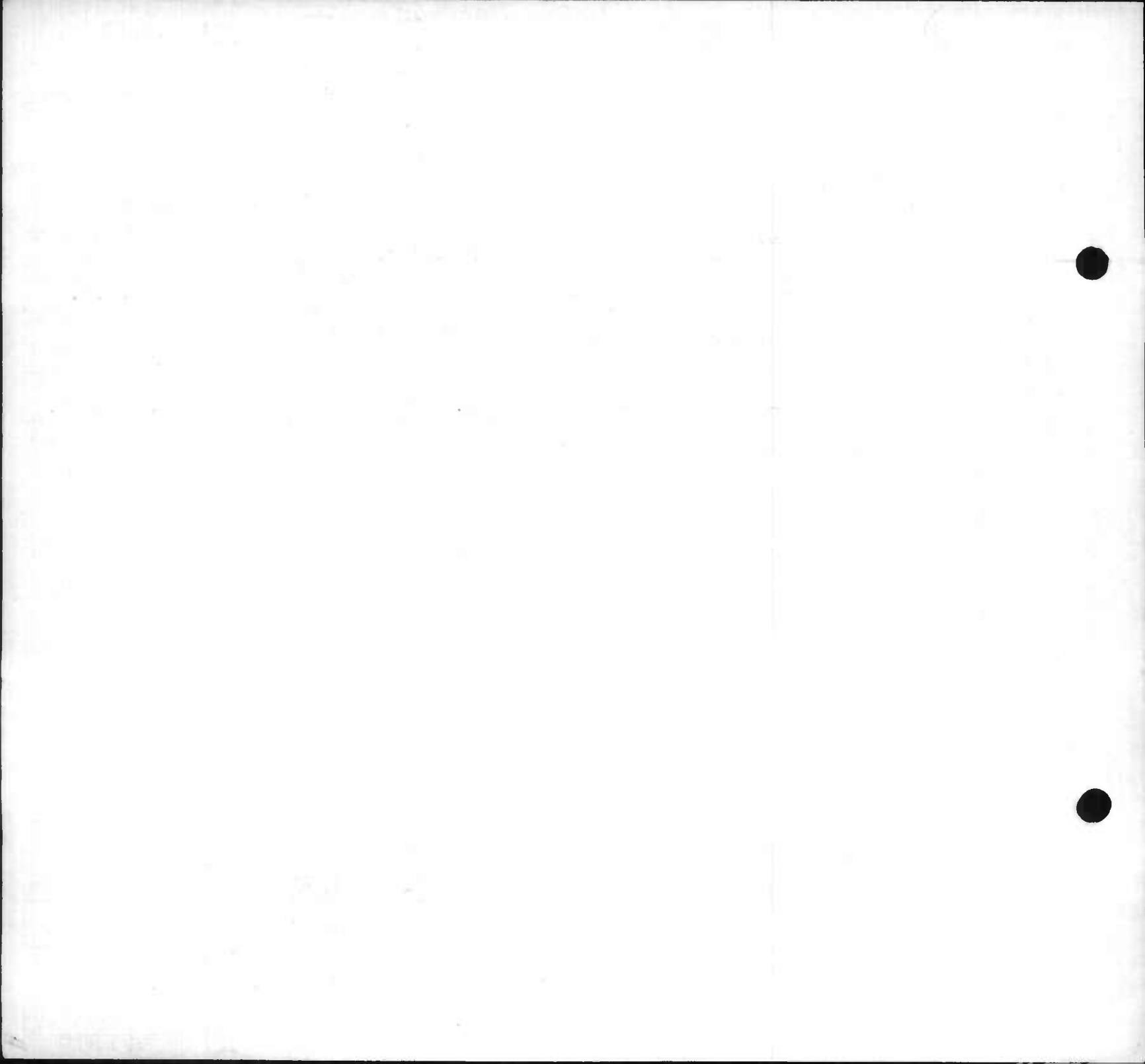
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1964

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

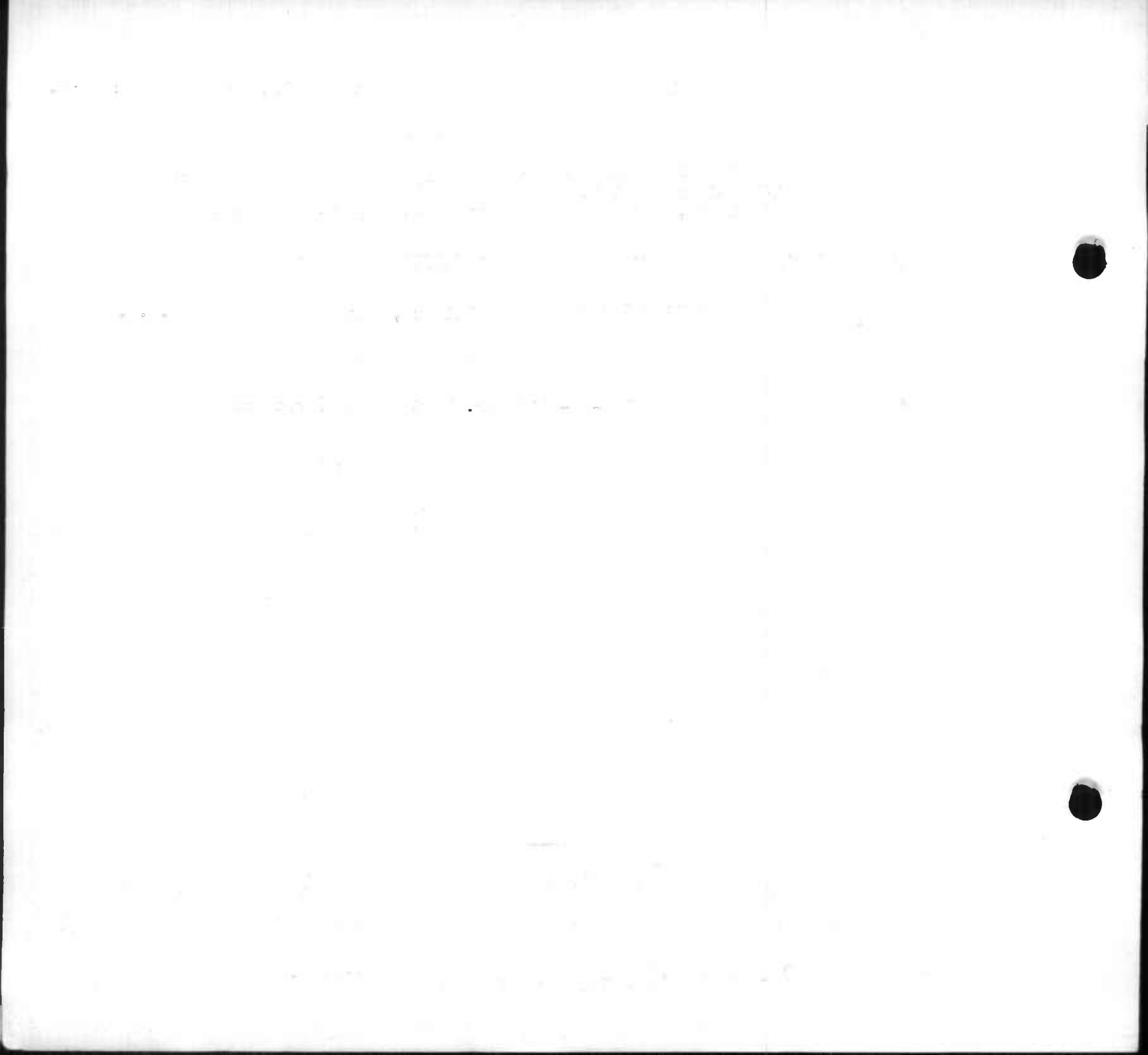
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8947</u>	
BIRTH NO. <u>D-412 71 8947</u>				1. NAME OF DECEASED Type or Print <u>MR. WACLAW DLABICH</u>		2. DATE AND HOUR OF DEATH <u>9-22-71</u> <u>4:50 A. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospital</u> <u>Church Home & Hospice</u>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>113 S. Ann Street</u>			
5. SEX <u>Male</u> <u>M</u>	6. RACE <u>White</u> <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-05-88</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Longshoreman, Ship Cargo Loading</u>				10B. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Poland</u> <u>Poland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> <u>American U.S.A.</u>
13. FATHER'S NAME <u>Alexander Dlabich</u>				14. MOTHER'S MAIDEN NAME <u>Anna Trzcinska</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-01-0716</u>		17. INFORMANT <u>Mrs. Catherine Dlabich, 113 S. Ann St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Cerebrovascular Accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension, ASCVD, Atrial Fibrillation</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-10</u> <u>19 71</u> to <u>9-22</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>9/22</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ma. Elena V. Manley</u> <u>M.D.</u>				23B. DATE SIGNED <u>9-22-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>MA. ELENA V. MANLEY</u> <u>M.D.</u>				23D. ADDRESS <u>Church Home & Hospice</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/25/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Sacred Heart of Mary</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

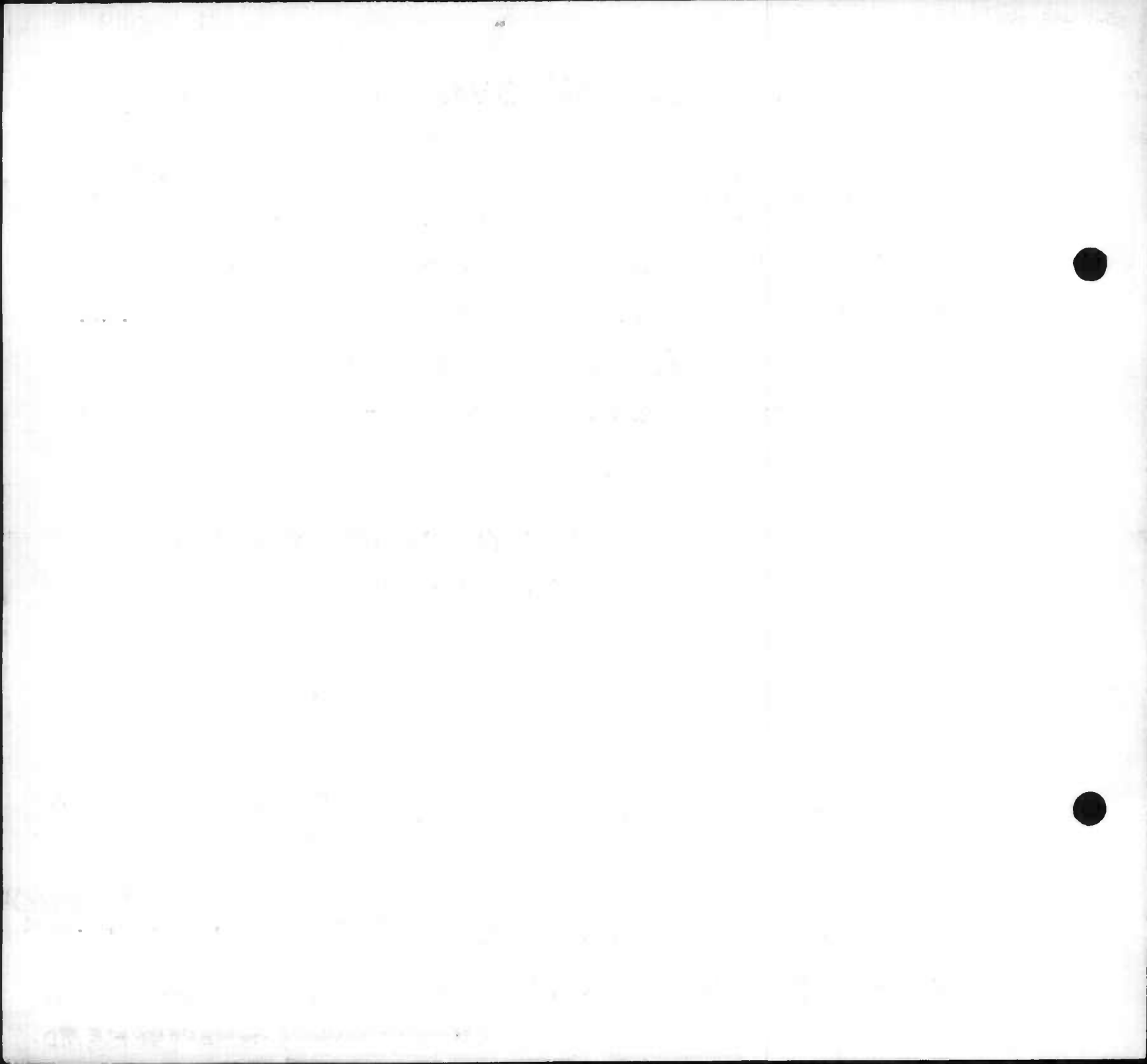
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

#252 71 8948		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8948	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary Hawkins		September 22, 1971 2:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
39 Provident Hospital Complex 2600 Liberty Heights Baltimore, Maryland			Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3300 Auchentholroy Terrace		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
Female	Black	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/25/13	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Metro D.		Merchant Club		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
David Owens			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		100-03-9415		Mr. David Owens (Brother) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			I day		
II			unknown		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			unknown		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
none				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/22 19 71 to 9/22 19 71 that (I) (we) last saw the deceased alive on 9-22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Aurora C. Tan, M.D.				9/22/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
AURORA C. TAN M.D.				PROVIDENT HOSP., BALTIMORE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-22-71		Arbutus Mem PK	
				Arbutus Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 24 1971		Robert E. Galt, R.D.O.		J. R. Russ 2222-24 NORTH AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

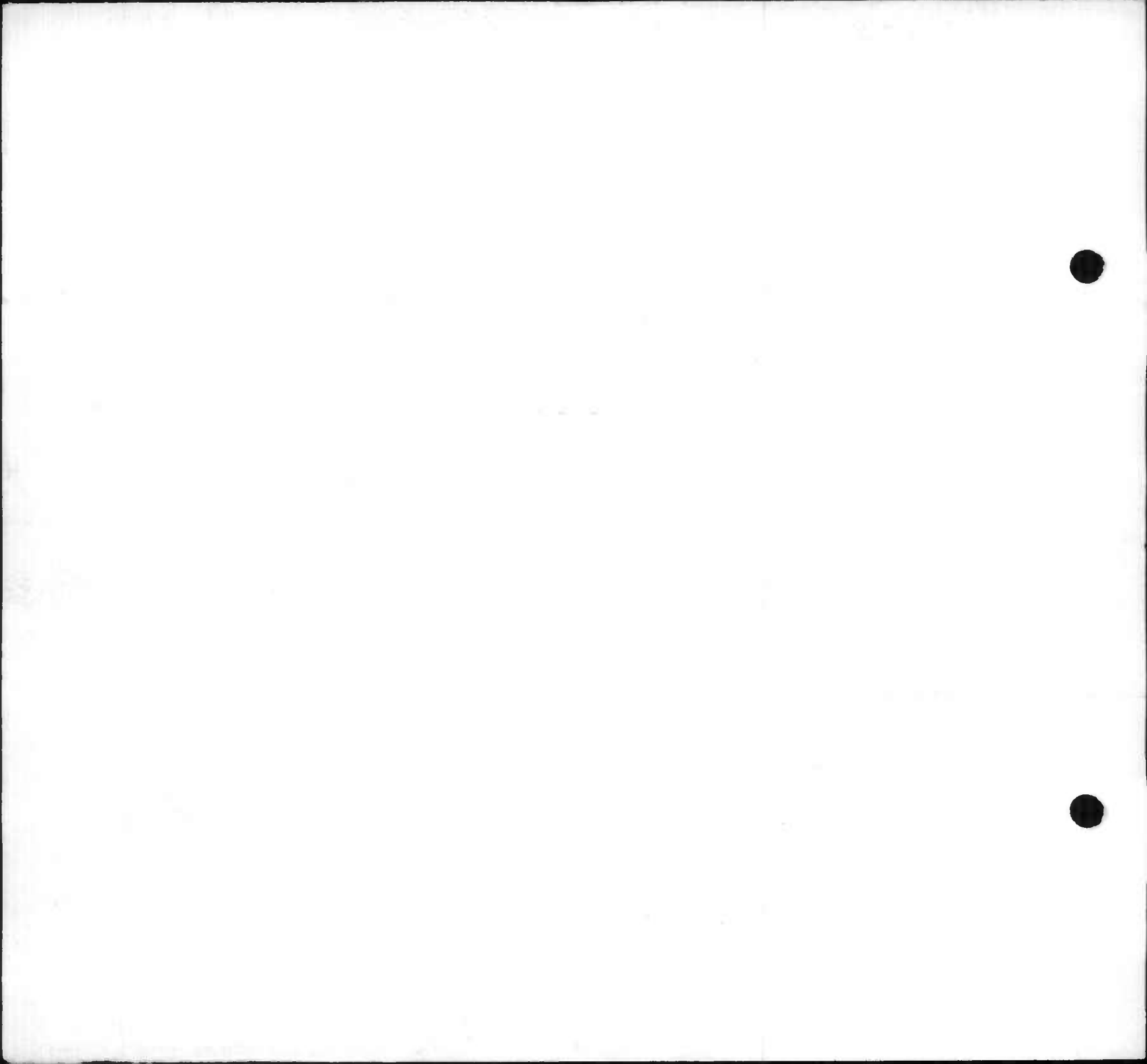
U-325 71 8949		BALTIMORE CITY HEALTH DEPARTMENT		71 8949	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Widdekind, Emily WOLFE		2. DATE AND HOUR OF DEATH 20 September 1971 6:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		B. COUNTY Harford	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md, 21224		C. CITY OR TOWN Havre De Grace		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 525 Camilla Street 21078		5. SEX Female		6. RACE Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-3-1900		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Chester IRWIN		14. MOTHER'S MAIDEN NAME LOUISE Emma Wolfe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 263-50-8117		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Shock DUE TO, OR AS A CONSEQUENCE OF: (B) Probable Gram Negative Sepsis DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple Myeloma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4 Sept 19 71 to 20 Sept 19 71 that (I) (we) last saw the deceased alive on 20 Sept 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Gary M Kammer MD		23B. DATE SIGNED 20 September 1971		23C. PHYSICIAN'S NAME (Type) Gary M Kammer MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-23-1971		24C. NAME OF CEMETERY or CREMATORY ANGEL HILL CEM.	
24D. LOCATION (City, town, or county) (State) Havre De Grace, Harford, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR R. Madison Mitchell	
25C. FUNERAL DIRECTOR ADDRESS Havre De Grace, Md.		25D. NAME OF REGISTRAR R. Madison Mitchell		25E. FUNERAL DIRECTOR ADDRESS Havre De Grace, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 71 8950 BALTIMORE CITY HEALTH DEPARTMENT 71 8950 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>			
BIRTH NO. <u>5-346</u> 1. NAME OF DECEASED (Type or Print) <u>DOREEN STOLWORTHY</u>		2. DATE AND HOUR OF DEATH <u>9/21/71</u> <u>8:15 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Woodlawn</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3124 Rices Lane 21207</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 30, 1901</u>
9. AGE (in years last birthday) <u>69</u>		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min.: _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>MANCHESTER, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM PARKER</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE (CADMUS)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>039-07-6440</u>	
17. INFORMANT <u>HARVEY L. STOLWORTHY RICES LANE</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>36 hrs</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>MYOGENIC THROMBOSIS (probable)</u> <u>36 hrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>9/21/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/21/71</u> to <u>9/21/71</u> that (I) (we) last saw the deceased alive on <u>9/21/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Francis T. Daly</u>		23B. DATE SIGNED <u>9/21/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Francis T. Daly MD</u>		23D. ADDRESS <u>11 R CHASE ST Baltimore Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>XXXXXX CREMATION</u>		24B. DATE <u>9/23/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CREMATORY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>	
25C. FUNERAL DIRECTOR <u>1920</u>		ADDRESS <u>8728 Liberty Road 21133</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8951</u>	
H-532 71 8951				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HOWARD E. HENTZ</u>		2. DATE AND HOUR OF DEATH <u>9/21/71</u> <u>12:30 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1306</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1802 EUTAW ST.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/86</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Crown Bolt & Nut Co. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-0564</u>		17. INFORMANT <u>Howard J. Davis 25 Belmore Rd 21093</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Stroke - Rt side hemiplegia</u> (B) <u>ASC VD -</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>UTI - Pneumonia</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Not done</u>		20A. AUTOPSY? (Yes or No) <u>Not done</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Not done</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>9/21/71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/21/71</u> to <u>9/21/71</u> that (I) (we) last saw the deceased alive on <u>9/21/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>9/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>GAKUBA MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 23 1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md.</u>		24E. FUNERAL DIRECTOR <u>Paul G. [Signature]</u>		24F. ADDRESS <u>3615 Chestnut Ave.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u> 25C. FUNERAL DIRECTOR <u>Paul G. [Signature]</u>					

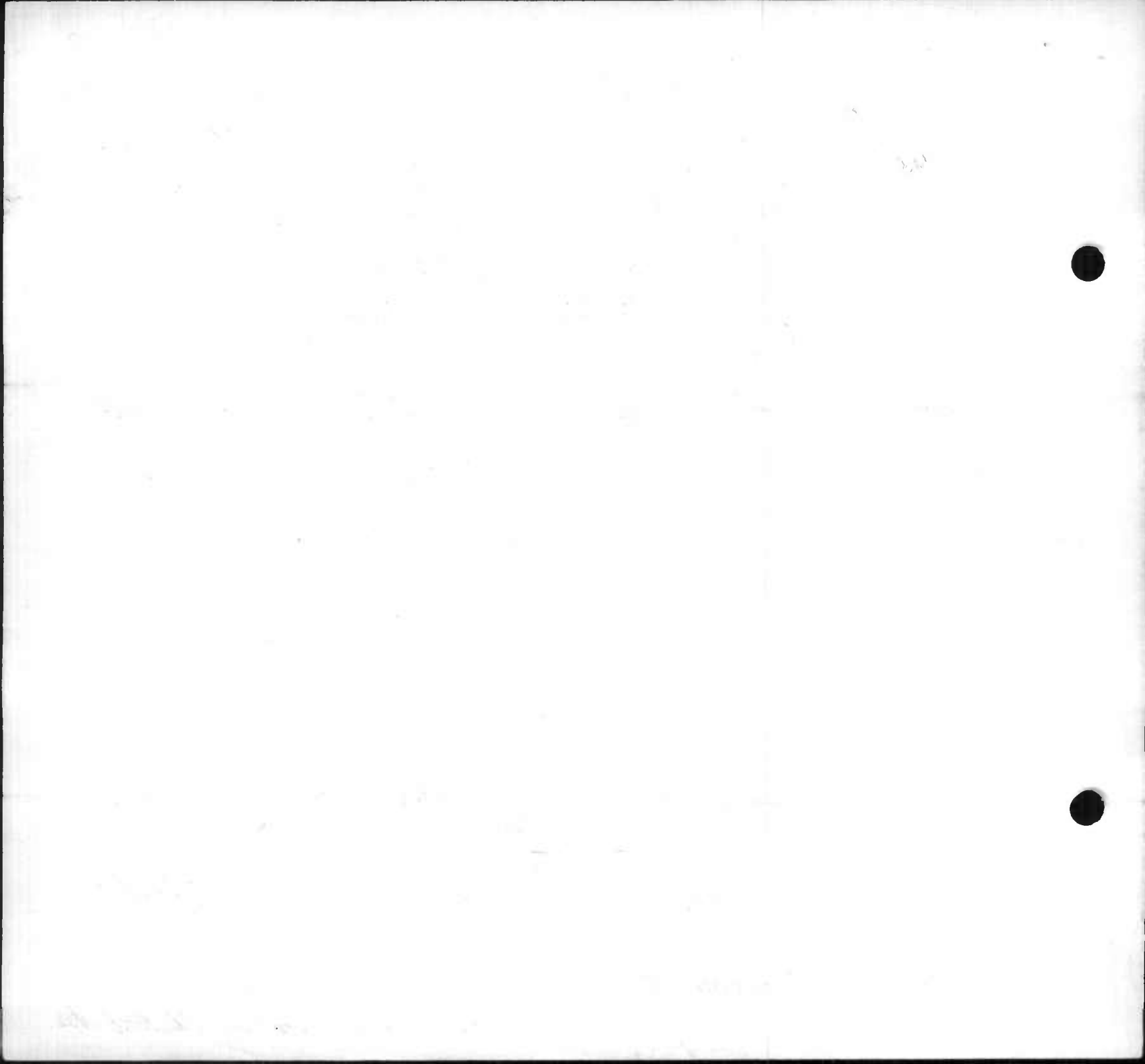
3450 EIM AVE.

Adm. 5/9/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 8952</u>	
BIRTH NO. <u>T-220</u> <u>71 8952</u>		1. NAME OF DECEASED (Type or Print) <u>ALEXANDER G ISAAC</u>	
2. DATE AND HOUR OF DEATH <u>9/18/71</u> <u>1:10 P.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House in the Pines - Belair Pk.</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1306.</u>		5. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. STREET AND NUMBER <u>608 W. 33rd St</u>		7. SEX <u>Male</u> 8. RACE <u>White</u> 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. DATE OF BIRTH <u>April 9, 1880</u> 11. AGE (in years last birthday) <u>91</u>		12. IF Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Insp.</u>		14. KIND OF BUSINESS OR INDUSTRY <u>Balto City</u>	
15. BIRTHPLACE (State or foreign country) <u>MD.</u>		16. CITIZEN OF WHAT COUNTRY?	
17. FATHER'S NAME <u>?</u>		18. MOTHER'S MAIDEN NAME <u>?</u>	
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		20. SOCIAL SECURITY NO. <u>226-44-7285</u>	
21. INFORMANT <u>Wm A Isaac</u>		22. ADDRESS <u>608 W. 33rd St.</u>	
23. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anteriorly Heart Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Arteriosclerosis</u>		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Post op Fracture of femur; Renal Urinary Tract Disease</u>			
26. DATE OF OPERATION <u>9/12/71</u>		27. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture of femur</u>	
28. AUTOPSY? (Yes or No) <u>No</u>		29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>608 W 33rd St</u>		33. HOW DID INJURY OCCUR? <u>fell down steps</u>	
34. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>6/9/71 6:15 P</u>		35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
36. I certify that (1) <u>(No hospital)</u> attended the deceased from <u>9/10/71</u> to <u>9/18/71</u> and that (2) <u>(No)</u> last saw the deceased alive on <u>9/10/71</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>(No)</u> (did) <u>(did not)</u> view the body after death.			
37. SIGNATURE <u>Albert B Bunchy</u>		38. DATE SIGNED <u>9/18/71</u>	
39. PHYSICIAN'S NAME (Type) <u>Albert B Bunchy</u>		40. ADDRESS <u>3615 Chestnut Ave.</u>	
41. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		42. DATE <u>Sept 22, 1971</u>	
43. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		44. LOCATION (City, town, or county) (State) <u>Balto Co</u>	
45. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1971</u>		46. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
47. FUNERAL DIRECTOR <u>Paul C. Chinn</u>		48. ADDRESS <u>3615 Chestnut Ave.</u>	



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71 8953		BALTIMORE CITY HEALTH DEPARTMENT		71 8953	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) CLARENCE THOMAS			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1503 N. Wolfe St.			3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 1971 10:05 p.m.		
6. SEX male			7. RACE negro		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			C. CITY OR TOWN Balto.		
9. DATE OF BIRTH 8-24-35			10. AGE (In years last birthday) 36		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Clarence Thomas			14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 807		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME Evelyn Fooks			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
17. SOCIAL SECURITY NO. 215-30-2818			18. INFORMANT ADDRESS Donald Fooks 4801 Palmer Ave.		
19. 304.9 I CAUSE OF DEATH Acute intravenous narcotism (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2					
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-20-71		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/25/71		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			

ACADEMY BOND

FOR CONTENT

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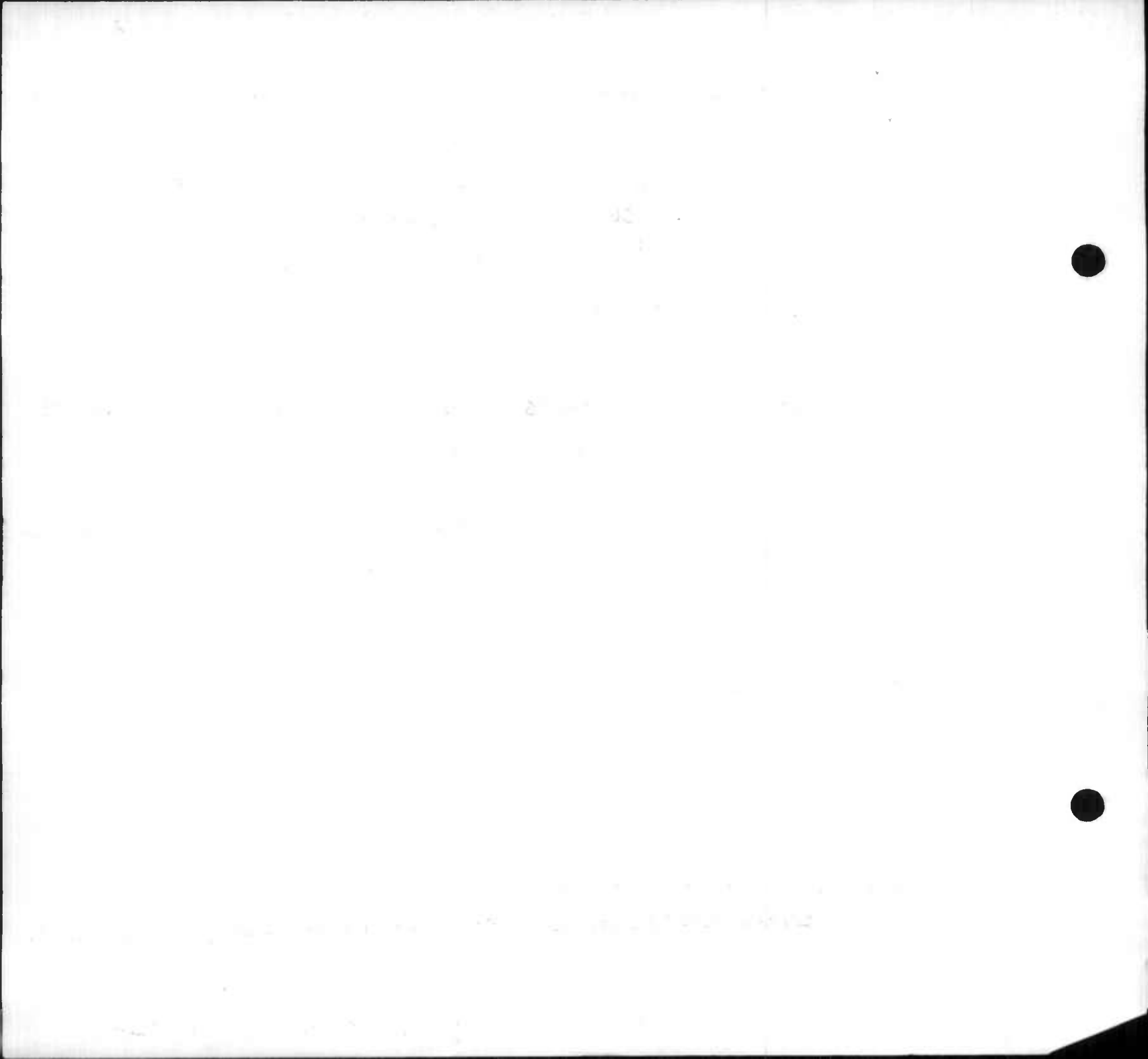
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

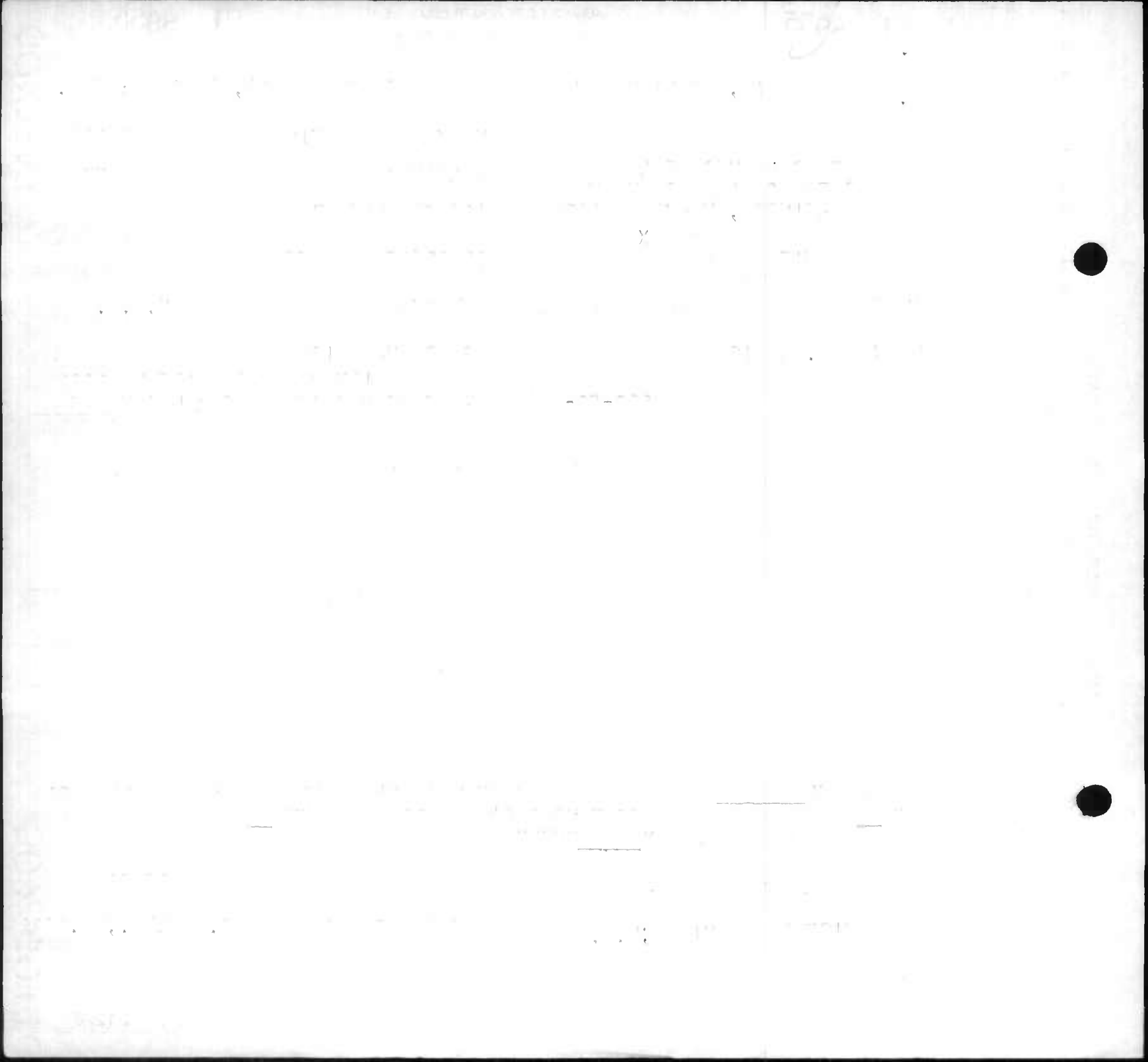
BIRTH NO. 71 8954		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8954	
1. NAME OF DECEASED (Type or Print) Wilson William Meyers			2. DATE AND HOUR OF DEATH 9/23/71 7:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1711 Casadel Avenue Baltimore, Md. 21230			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2582 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1711 Casadel Avenue		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/9/15	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) deputy clk sup. court		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Meyers		
14. MOTHER'S MAIDEN NAME Sara R			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		
16. SOCIAL SECURITY NO. 214-01-5876			17. INFORMANT Mrs. Helen Meyers, 1711 Casadel Ave., 21230		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) METASTATIC ADENO-CARCINOMA LIVER DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) ADENO-CARCINOMA TRANSVERSE COLON (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4 1/2 years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/25/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Laparotomy		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JAN. 7/1967 19 67 to 9/23 19 71 that (I) (we) last saw the deceased alive on September 14 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen K. Padussis M.D.			23B. DATE SIGNED 9/24/71		23C. PHYSICIAN'S NAME (Type) Stephen K. Padussis, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/27/71		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228		



FUNERAL DIRECTOR: IMPORTANT

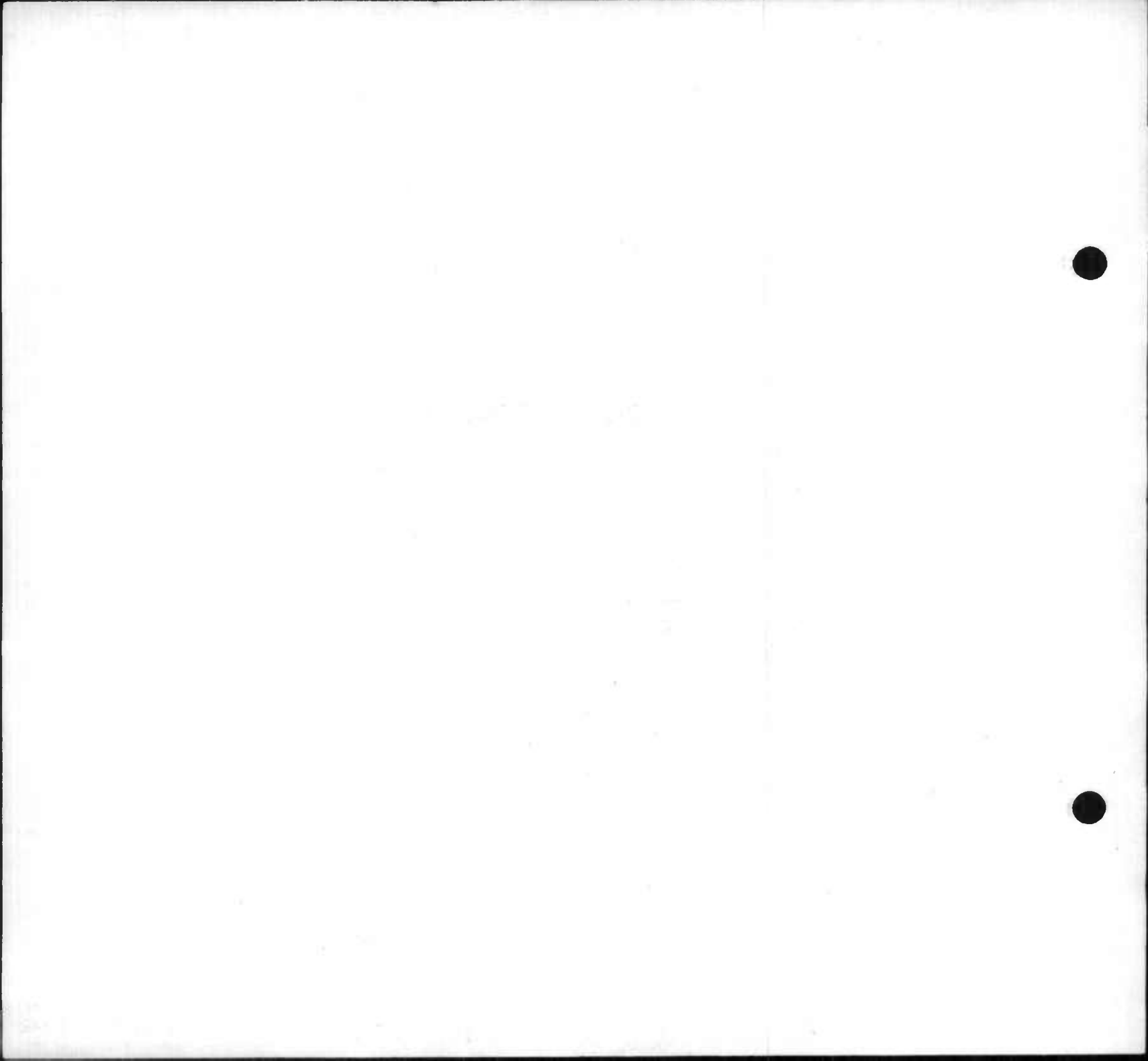
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

JMK L2100		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8955	
71 8955		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LEWIS, WILLIAM EDWARD		SEPTEMBER 24, 1971 7:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		B. COUNTY BALTIMORE	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/12/15		9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM E. LEWIS	
14. MOTHER'S MAIDEN NAME GRACE HEIMLICH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 213-01-6348	
17. INFORMANT WILKENS AVES BALTO MD 21229 ST AGNES HOSPITAL RECORDS CATON &		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2/1 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 24 19 71 to SEPTEMBER 24 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 24 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. 23A. SIGNATURE Benauides MD 23B. DATE SIGNED 9 25 71 23C. PHYSICIAN'S NAME (Type) VICTOR BENAVIDES, M.D. 23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/28/71 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. 25C. FUNERAL DIRECTOR Witzke ADDRESS 1630 Edmondson Avenue 21228			



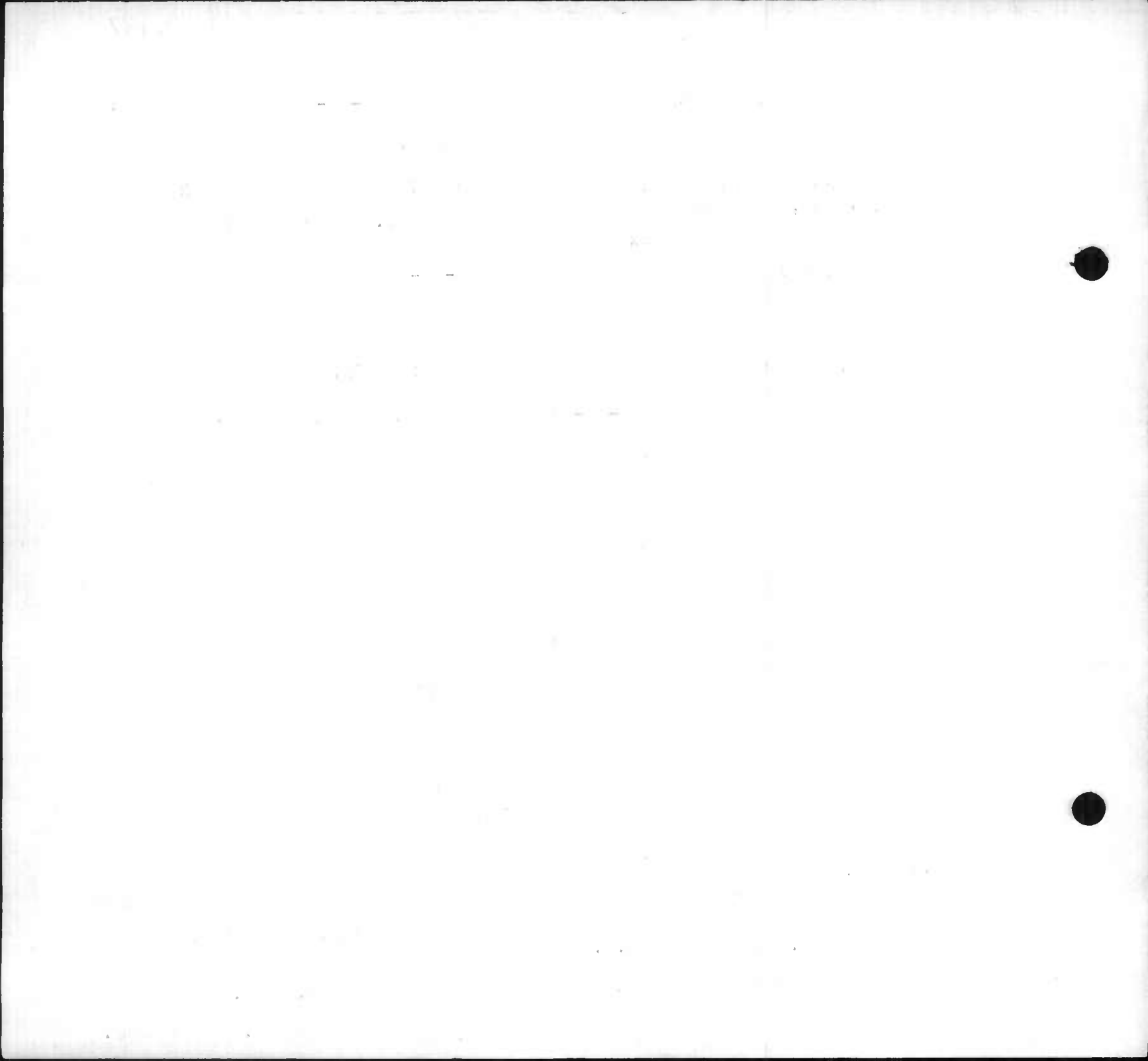
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8956</u>	
<p>1. NAME OF DECEASED (Type or Print) <u>ROSENDO LORENTE</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9/26/71</u> <u>4:45</u> <u>A</u> <small>M.</small></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 JOWNS HOPKINS HOSPITAL</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1205</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>416 E LAWVARE STREET</u></p>			
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>C</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>2/26/193</u></p>	<p>9. AGE (In years last birthday) <u>78</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMAN</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>PHILIPPINES</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>MARIANO LORENTE</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>TRE DORA LABA RRETE</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>216-12-0823</u></p>		<p>17. INFORMANT <u>MRS LESSIE M. LORENTE</u></p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA - ACUTE RENAL FAILURE</u></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>UREMIA - ACUTE RENAL FAILURE</u> <u>DAYS</u></p>			
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC RENAL INSUFFICIENCY</u> <u>YEARS</u></p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u>UNDERSTANDING METASTATIC COLOM CARCINOMA</u> <u>MRS.</u></p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>UNDERSTANDING METASTATIC COLOM CARCINOMA</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u></p>			
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>YES</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u></p>		<p>(If in Baltimore City, give exact location)</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>		<p>21C. WHERE DID INJURY OCCUR?</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> <u>1971</u> to <u>9/26</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>9/26</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Robert C Bent Jr. MD</u></p>		<p>23B. DATE SIGNED <u>9/26/71</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>ROBERT C. BENT, JR., MD</u></p>	
<p>23D. ADDRESS <u>JOWNS HOPKINS HOSPITAL</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>			
<p>24B. DATE <u>9-29-71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>2022 71 000</u></p>		<p>25C. FUNERAL DIRECTOR <u>W. A. C. MARCH</u></p>	
<p>ADDRESS <u>928 E NORTH AVE</u></p>		<p>VS 150-REV. 1/1/68</p>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

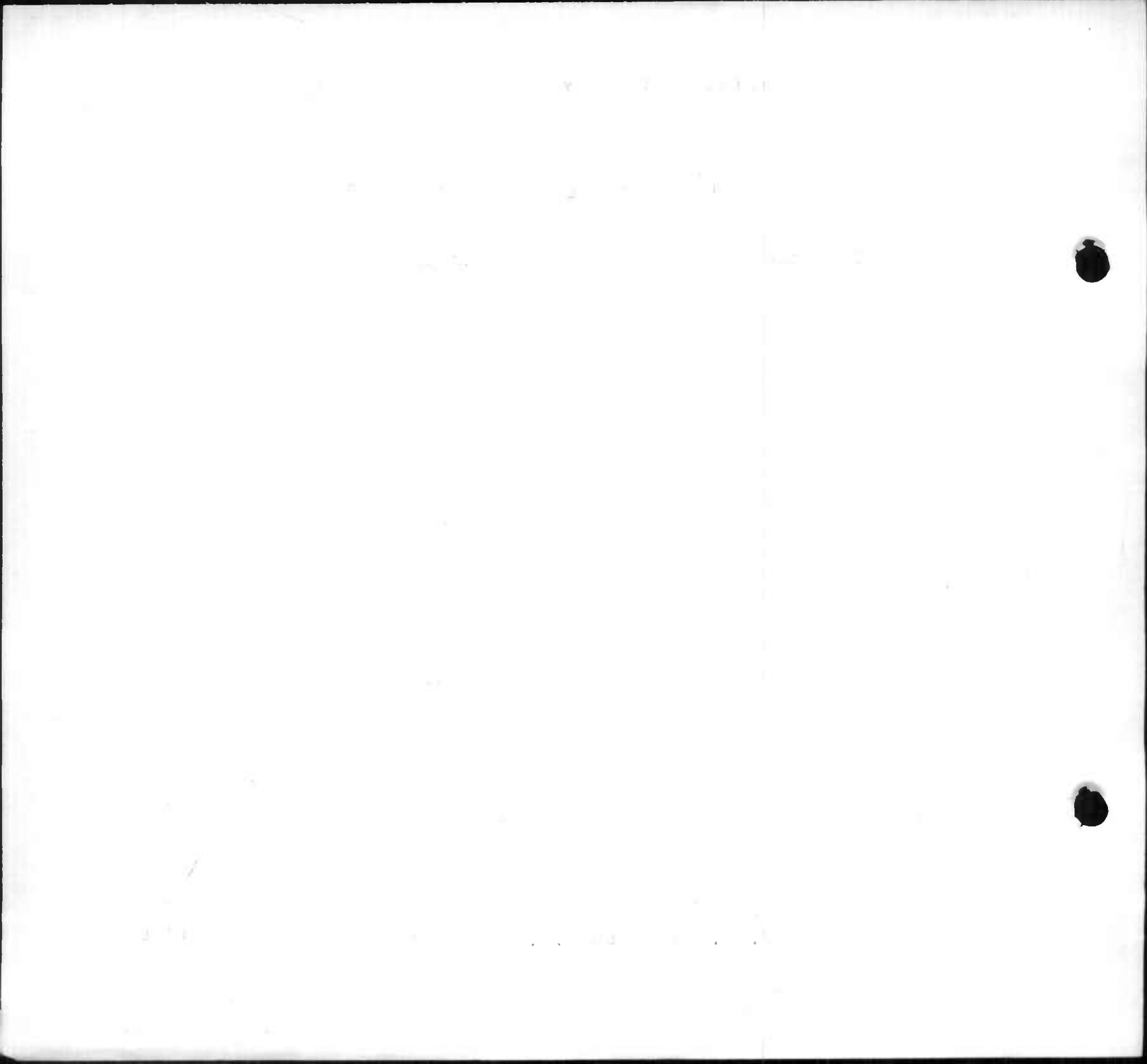
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				71 8957	
BIRTH NO. 71 8957		2. DATE AND HOUR OF DEATH 09-26-71 1:05 A. M.			
1. NAME OF DECEASED (Type or Print) CLARENCE SWANN		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1002			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1241 E. EAGER STREET					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-15-15	9. AGE (in years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME CHARLIE SWANN			
14. MOTHER'S MAIDEN NAME ANNIE TRENT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 255-12-3424		17. INFORMANT Eliza F. Swann 1241 E. Eager Street			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrhythmia		5 min	
		(B) Probable pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF:		Intermittently 8 months	
		(C) Prostatic carcinoma, metastatic		2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic renal failure					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 7 19 71 to Sept 26 19 71 that (I) (we) last saw the deceased alive on Sept 26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martha L. Kopper, M.D.		23B. DATE SIGNED 9/26/71		23C. PHYSICIAN'S NAME (Type) MARTHA L. KOPPER M.D.	
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9-30-71		24C. NAME OF CEMETERY OR CREMATORY Balto. Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Am O Moran	
25D. ADDRESS 928 E. North Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-532 71 8958		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8958	
1. NAME OF DECEASED Type or Print PEARL BEATRICE MONTGOMERY		2. DATE AND HOUR OF DEATH 9-23-71 2:35 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE SOUTH CAROLINA B. COUNTY V-37			
5. SEX FEMALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-97		9. AGE (in years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Will Little John		14. MOTHER'S MAIDEN NAME Mary		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT George Montgomery ADDRESS 3112 Elbert St.	
18. 15501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE Hepatitis DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 3 19 71 to Sept 23 19 71 that (I) (we) last saw the deceased alive on September 23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Varnell M.D.		23B. DATE SIGNED Sept. 23, 1971		23C. PHYSICIAN'S NAME (Type) J. S. VARNELL M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-71		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Balto., Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Am C March ADDRESS 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>8959</u>
BIRTH NO. <u>S-536</u> <u>71</u> <u>8959</u>				
1. NAME OF DECEASED (Type or Print) <u>Jeffrey Saunders</u>		2. DATE AND HOUR OF DEATH <u>23 September 1971</u> <u>9:31 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1303</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>XXXXX</u> <u>2432 MADISON AVE.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-63</u>	9. AGE (In years last birthday) <u>8</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York City</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>ALBERT PAGE</u>		
14. MOTHER'S MAIDEN NAME <u>KATIE SAUNDERS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Katie Page, same</u>		
18. <u>2079 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Leukemia</u>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from <u>7 September 1971</u> to <u>23 September 1971</u> that (we) lost saw the deceased alive on <u>23 September 1971</u> and that in (our) opinion death occurred on the date and hour end from the causes stated above. (We) (did) view the body after death.				
23A. SIGNATURE <u>Roger A. Brumback M.D.</u>		23B. DATE SIGNED <u>9/23/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Roger A. Brumback M.D.</u>
23D. ADDRESS <u>Johns Hopkins Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>9/29/71</u>		24C. NAME of CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>		24D. LOCATION <u>Baltimore, Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>1206 W north Ave</u>

Arthur C. C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8960

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward Oliver

2. DATE OF DEATH Known ☒ Estimated ☐ Month 9 Day 21 Year 71 Hour 12:45 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Johns Hopkins Hospital

3. DATE PRONOUNCED DEAD Month 9 Day 21 Year 71 Hour 12:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

501

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7/7/24

10. AGE (In years lost birthday) ?

35

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1013 Monument Street

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
Louise Oliver

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lillie

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT
Mrs Margaret Oliver, Same ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Bronchopneumonia complicating
DUE TO, OR AS A CONSEQUENCE OF:

cerebral injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Unknown

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

Unknown

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

presumably fell

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-21-71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9/28/71

24C. NAME OF CEMETERY or CREMATORY

MT Calvary Cemetry

24D. LOCATION (City, town, or county) (State)

A A County Md

25A. DATE REC'D BY HEALTH DEPT

SEP 27 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

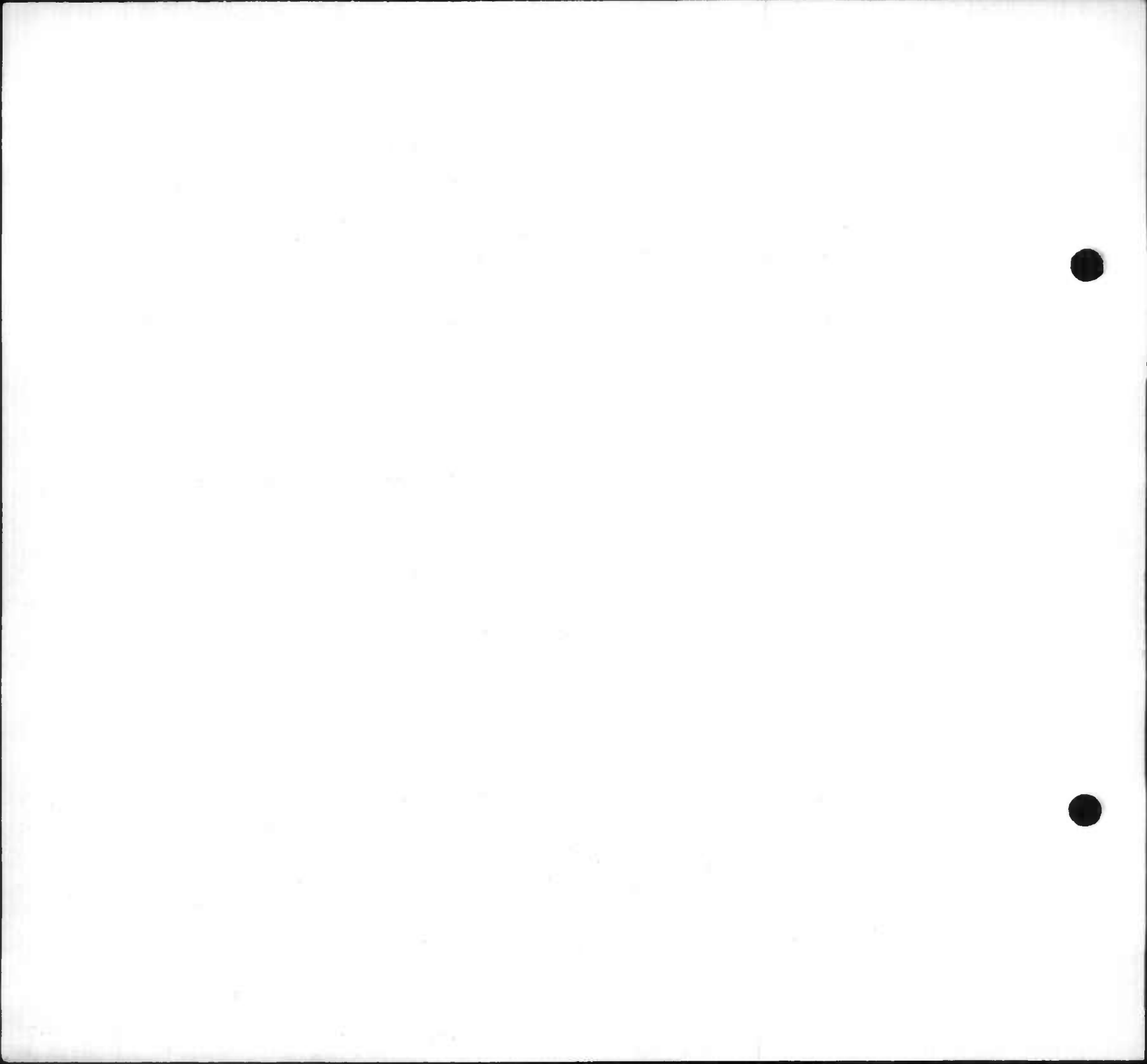
ADDRESS

Adolphus Halstead 1206 W North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

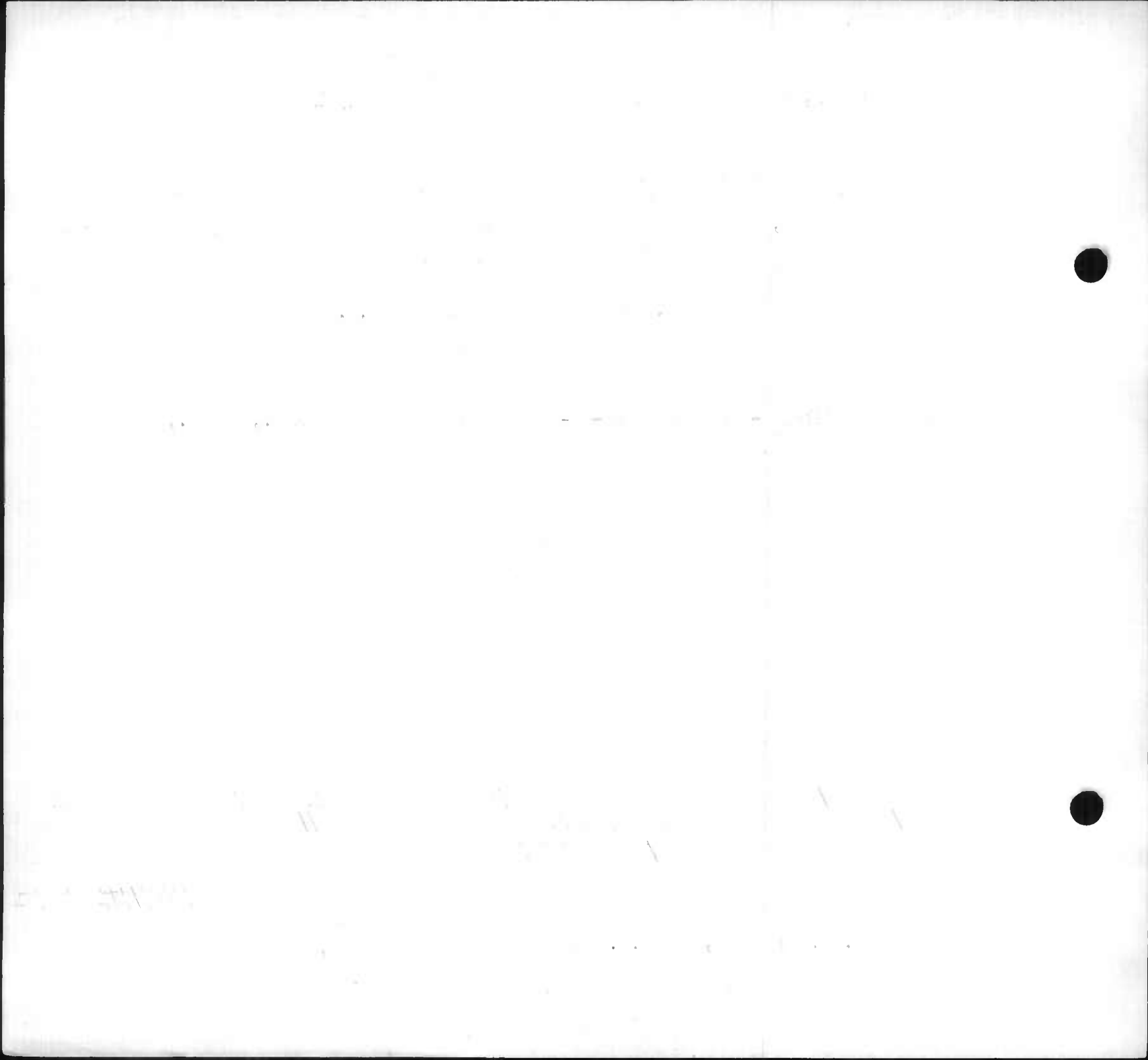
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 8961</u>	
BIRTH NO. <u>W-325 71 8961</u>				1. NAME OF DECEASED (Type or Print) <u>Phillip R. Watkins</u>		2. DATE AND HOUR OF DEATH <u>September 24 1971 11 45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND General Hospital</u> <u>48</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1403</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-94</u>	
9. AGE (in years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-4751</u>		17. INFORMANT <u>Margaret Watkins</u>		ADDRESS <u>Same</u>	
18. <u>1890 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>General Cachexia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Renal Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastases to hip</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Renal Cell Carcinoma / Met</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD + CHF</u>							
19A. DATE OF OPERATION <u>9-24-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>9-12-71</u> 19 <u>71</u> to <u>9-24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-24</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>George C. Sammons</u> DEGREE				23B. DATE SIGNED <u>9/24/71</u>		23C. PHYSICIAN'S NAME (Type) <u>George C. Sammons</u> DEGREE	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Adolphus H. H.</u>		25C. FUNERAL DIRECTOR <u>Adolphus H. H.</u>		ADDRESS <u>1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

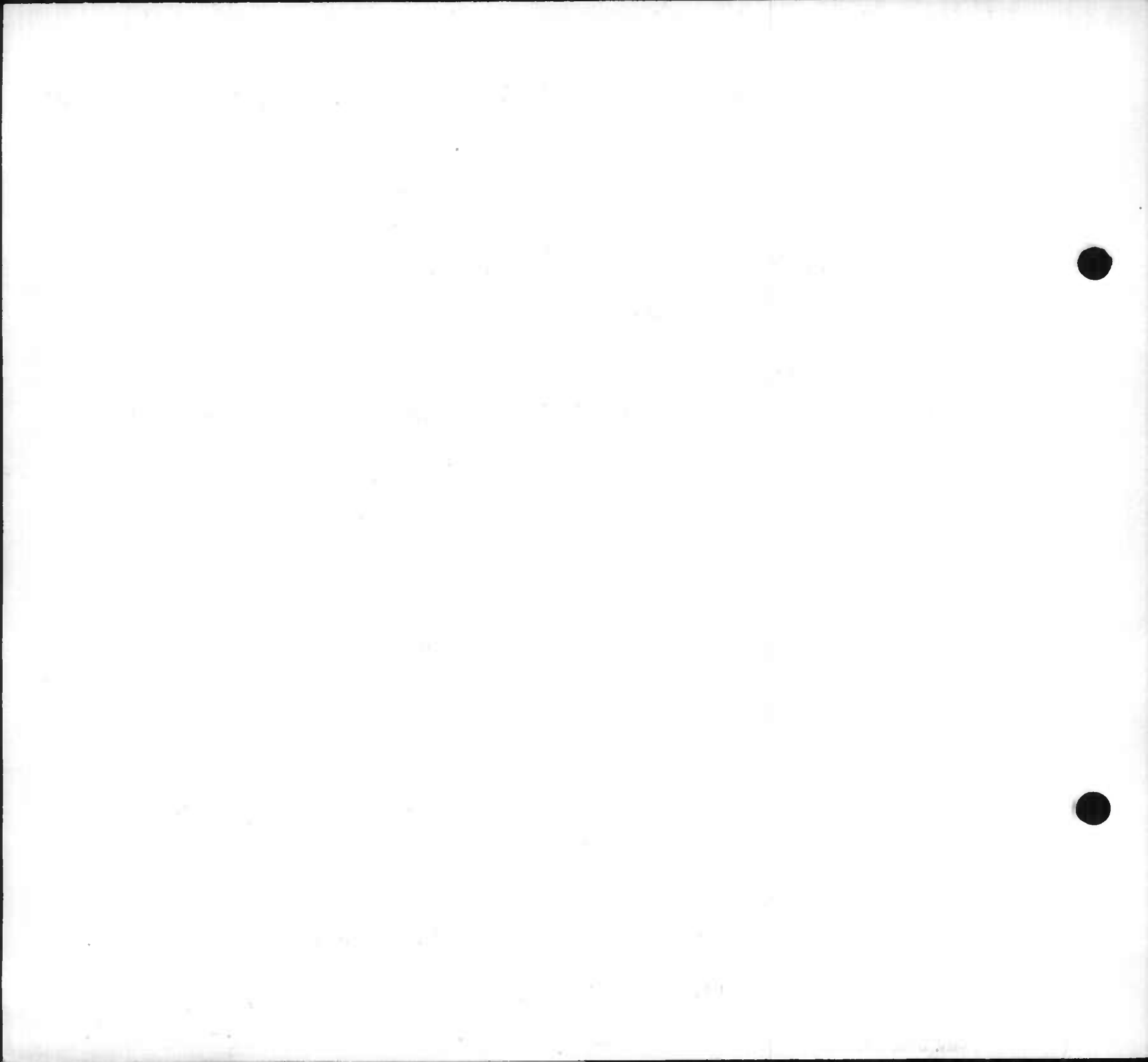
BALTIMORE CITY HEALTH DEPARTMENT				71 8962		71 8962	
CERTIFICATE OF DEATH				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) DIXON, GEORGE WASHINGTON				2. DATE AND HOUR OF DEATH 9/22/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1605 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2342 - Lauretta Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/92	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Horation S.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Dixon				14. MOTHER'S MAIDEN NAME Florence Kershaw			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/17/18 - 4/15/19				16. SOCIAL SECURITY NO. 216-03-6438A		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) STROKE AND CEREBRAL EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BRAIN METASTATIC CA TO BRAIN ALVEOLAR CELL CA OF LUNG				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 9/7 19 71 to 9/22 19 71 that (2) (we) last saw the deceased alive on 9/22/71 19 71 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE DH McDougal, MD				23B. DATE SIGNED 9/23/71 9/25/71		23C. PHYSICIAN'S NAME (Type) D. H. McDOUGAL, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9/29/71		24C. NAME OF CEMETERY OR CREMATORY Gettysburg National	
24D. LOCATION Gettysburg Pa				24E. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		24F. ADDRESS Adolphus Halstead 1206 W north Ave	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971				25B. NAME OF REGISTRAR Robert E. H. Bay, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

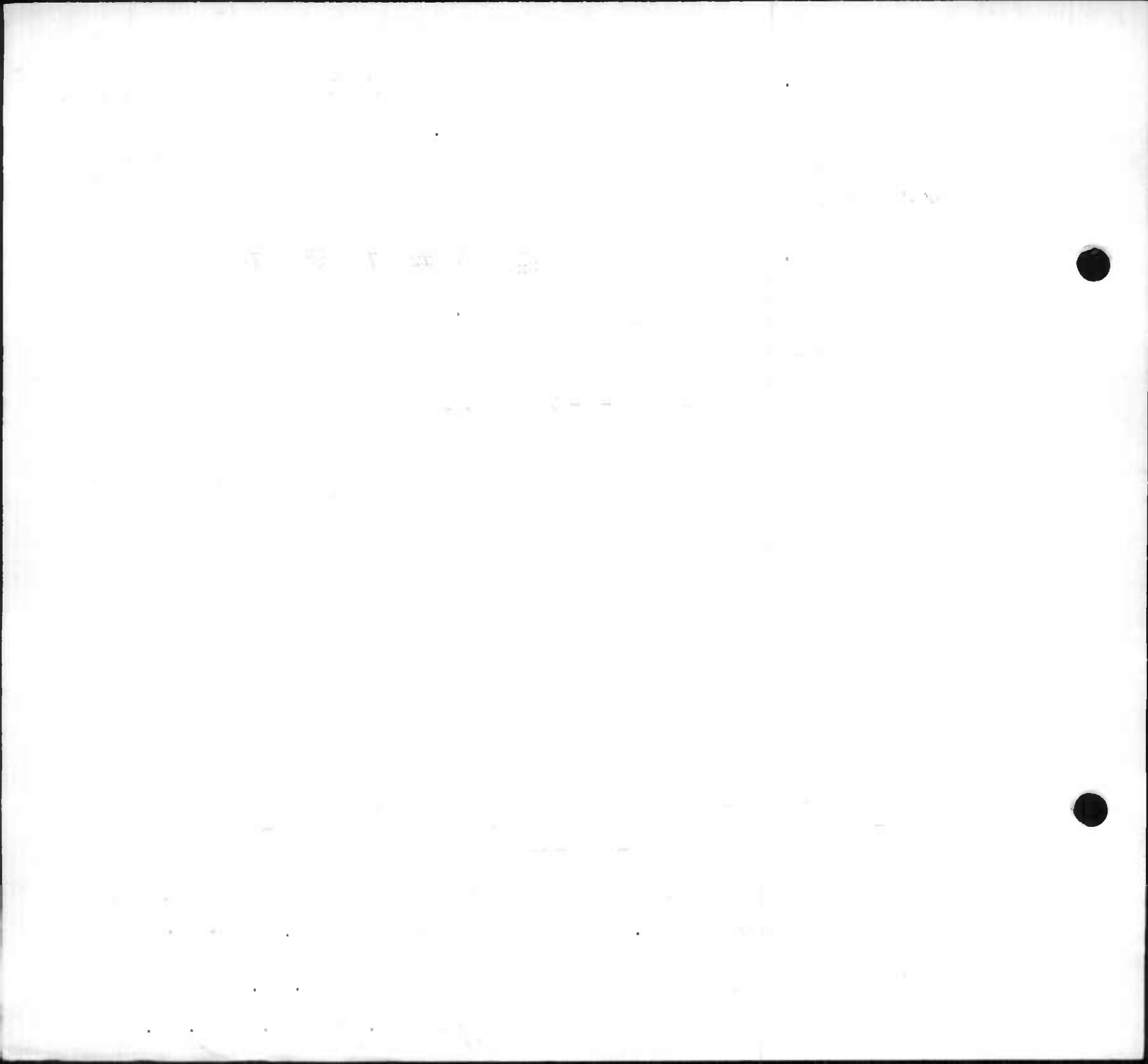
BIRTH NO. 71 8963		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 8963 REG. NO.	
1. NAME OF DECEASED (Type or Print) XXXXX John P KLEIDERLEIN		2. DATE AND HOUR OF DEATH Sept: 24, 1971 6 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 EDGEWOOD NURSING HOME 6000 Ballona Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Md. 2643			
5. SEX male		6. RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug 28 1889		9. AGE (In years last birthday) 82		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Feldmans		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Kleiderlein			
14. MOTHER'S MAIDEN NAME Sophia (Rosenberger)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217 09 7804		17. INFORMANT Mrs Ann Montgomery SAME ABOVE			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Osteoporosis spine					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 August 1971 to 24 September 1971 that (I) (we) last saw the deceased alive on 20 September 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby		23B. DATE SIGNED 24 Sept 71		23C. PHYSICIAN'S NAME (Type) Dr. John W. Barnaby	
23D. ADDRESS 1652 E. Belvedere Ave, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 27 71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			
25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		71 8964		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8964	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Paula P. Mayer				2. DATE AND HOUR OF DEATH 9/23/71 12:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Ardleigh Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2418 Lakewood Road					
5. SEX F	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/19/71 1897		9. AGE (in years) 74		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Schultze				14. MOTHER'S MAIDEN NAME Amelia Hallowig					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. 218-22-5706		17. INFORMANT Mrs. Ida Eybs same ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4124 I Arteriosclerotic cardio-vascular disease 5 yrs.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Senile psychosis 1 yr.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from September 3, 1971 to September 23, 1971 that (I) (we) last saw the deceased alive on September 22, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Lloyd E. Saylor MD.				23B. DATE SIGNED Sept. 24, 1971				23C. PHYSICIAN'S NAME (Type) Lloyd Saylor MD.	
23D. ADDRESS 3902 Greenmount Ave. Balto. Md.				23E. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/25/71		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.					



1

M-550

71

8965

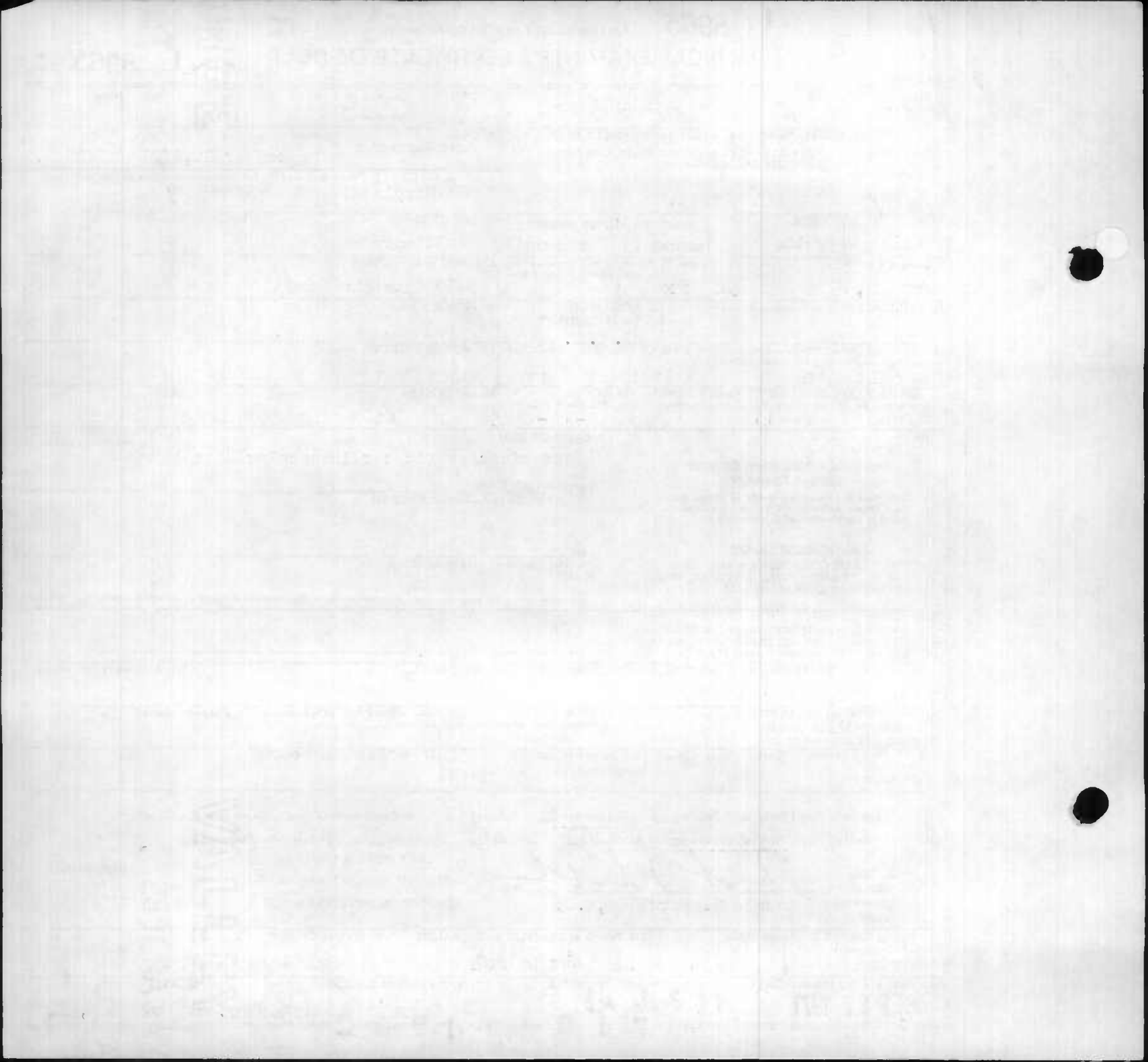
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 8965

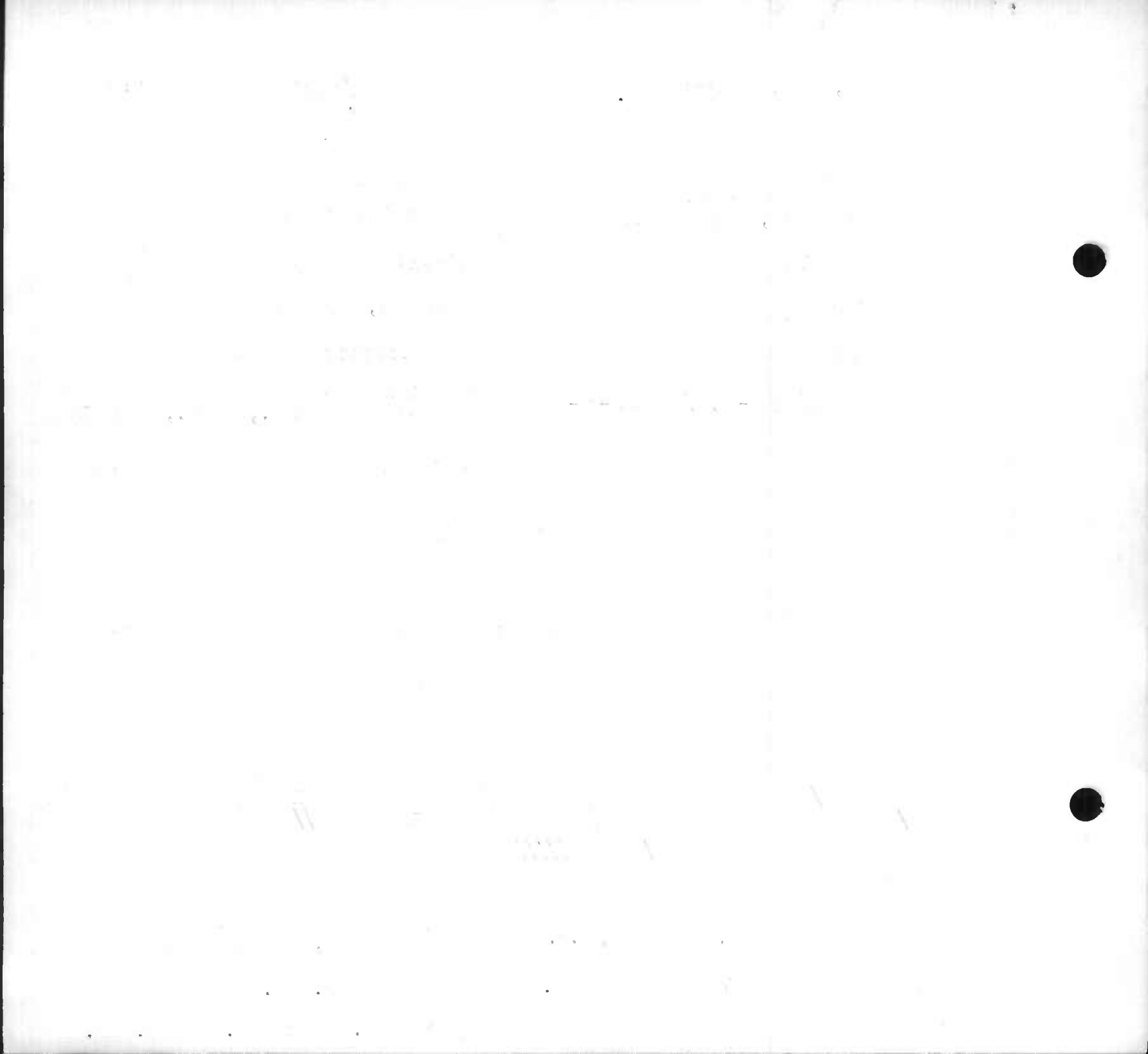
BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANDREW PAUL MOYNIHAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 22, 1971 2:40 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 2706			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH Aug 22, 1919
10. AGE (In years lost birthday) 52 5k		11. BIRTHPLACE (State or foreign country) Massachusetts	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew Moynihan		14. STREET AND NUMBER 5410 Catalpha Road	
15. MOTHER'S MAIDEN NAME Margaret ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11	
17. SOCIAL SECURITY NO. 014-14-0945		18. INFORMANT Mrs Catherine Moynihan	
19. 412.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 9/25/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 9/23/71 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9/25/71	24C. NAME of CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Md	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

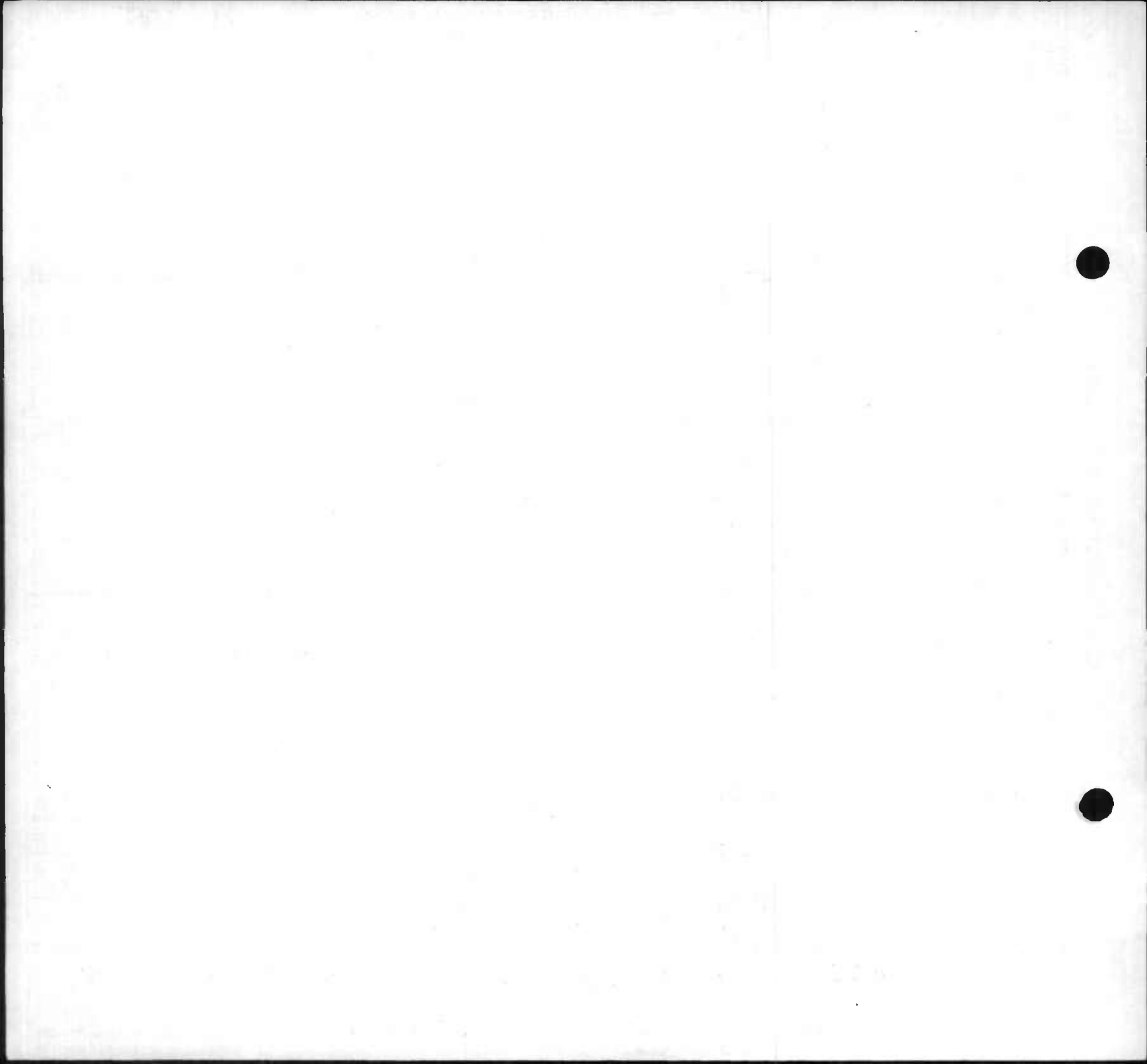
J-520		71 8966		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8966	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Jones, James Wallace Sr.				2. DATE AND HOUR OF DEATH 9/23/71 9:00 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 831					
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2841 Mayfield Ave									
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/26/15		9. AGE (In years last birthday) 56		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Contractor				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace Coppage				14. MOTHER'S MAIDEN NAME Emma Hadaway					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3/25/44-12/3/45				16. SOCIAL SECURITY NO. 119-07-2806		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Respiratory failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				months	
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Metastasis to brain								months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/30 19 71 to 9/23 19 71 that (I) (we) last saw the deceased alive on 9/23 19 71 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Stephen B. Greenberg, M.D.				23B. DATE SIGNED 9/23/71					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		9/27/71		Moreland Mem.		Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
SEP 27 1971		Robert E. Naylor, Jr.		Leonard J. Ruck Inc.		Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

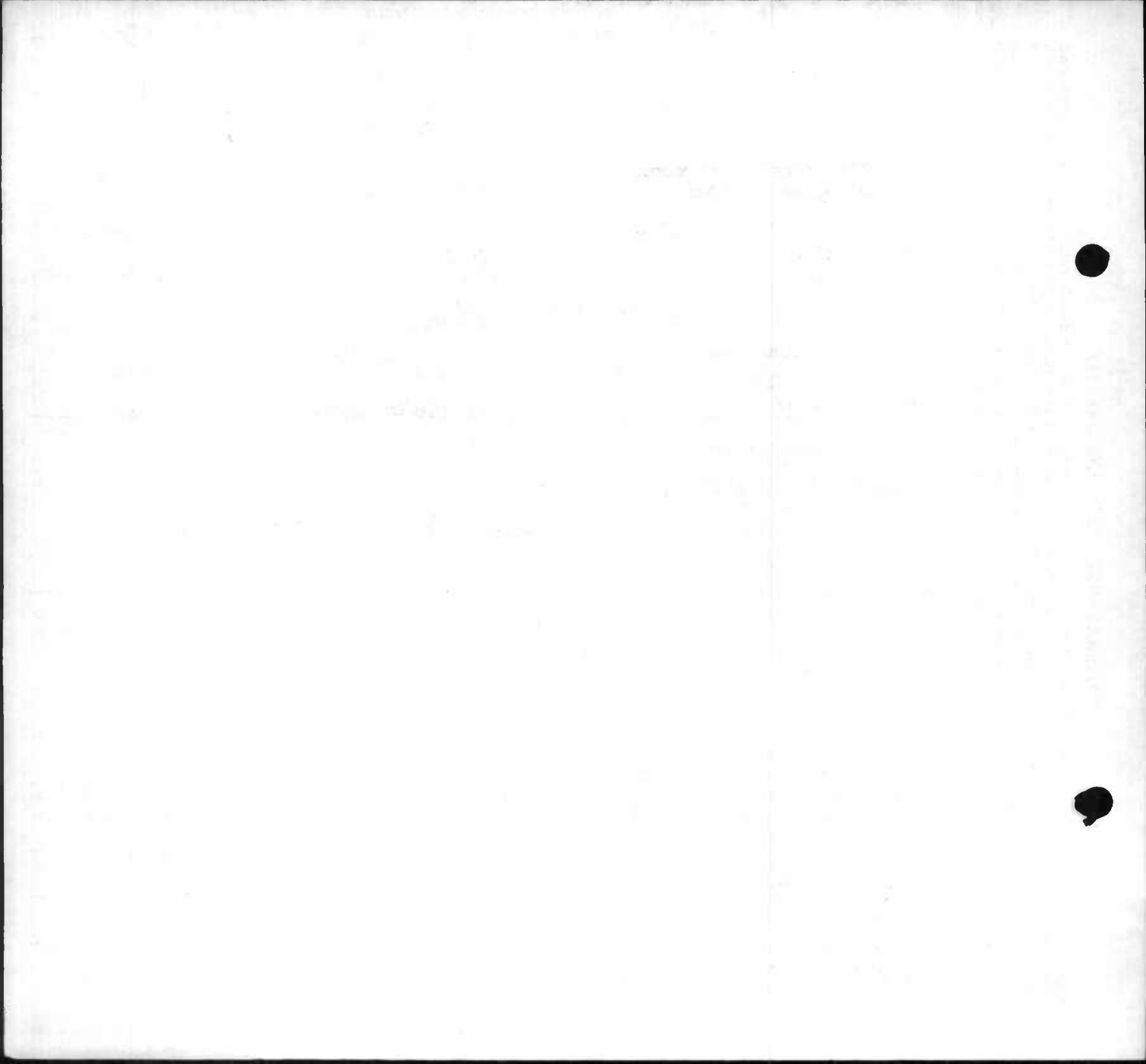
B-230 71 8967				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8967	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Irene Beckett</u>				2. DATE AND HOUR OF DEATH <u>Sept. 23, 1971</u> <u>12:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>A.A.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>8043 High Point Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19, 1895</u>	9. AGE (in years last birthday) <u>75</u>	10. Under 1 Yr. Months: <u> </u> Days: <u> </u>	11. Under 24 Hrs. Hours: <u> </u> Min: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>John Wholey</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Beckett Sr</u>	
18. <u>433914-2009</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple cerebral thrombosis</u> <u>Pulmonary pneumonia</u> (A) IMMEDIATE CAUSE <u>Diabetes mellitus</u> <u>Atherosclerotic heart disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u> </u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
21A. DATE OF OPERATION <u> </u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY (Yes or No) <u>No</u>		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Sept. 13</u> 19 <u>71</u> to <u>Sept. 23</u> 19 <u>71</u> that <u>(X)</u> (we) last saw the deceased alive on <u>Sept. 23</u> 19 <u>71</u> and that <u>(X)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Chiu Sung Chan, M.D.</u>				23B. DATE SIGNED <u>Sept. 23, '71</u>		23C. PHYSICIAN'S NAME (Type) <u>Chiu Sung Chan, M.D.</u>	
23D. ADDRESS <u>South Baltimore General Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Pk</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie AA Co Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Rosa Lee</u>		25C. FUNERAL DIRECTOR <u>M. Bulb, FH Mt & Trick Neck Rd</u>		ADDRESS <u>Rosa Lee</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO.		REG. NO.							
R-560		71 8968							
1. NAME OF DECEASED (Type or Print) <i>William E Roemer</i>				2. DATE AND HOUR OF DEATH <i>9/18/71</i> <i>10:30</i> P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hospital</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>40 St Agnes Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN <i>Pasadena</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>5200</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/11/71</i>	9. AGE (in years last birthday) <i>68</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City Water Dept</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Roemer</i>				14. MOTHER'S MAIDEN NAME <i>Lottie Ely</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 11</i>		16. SOCIAL SECURITY NO. <i>11</i>		17. INFORMANT <i>Mrs Ophelia Roemer</i>				ADDRESS <i>Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>71241-162-1</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>CARDIAC FAILURE - A.S.C.V.D</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ADVANCED PULMONARY EMPHYSEMA</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMA LEFT LUNG</i> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>2 YEARS</i> <i>DISCOVERED 1 WEEK AGO</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). MEDICAL CERTIFICATION <i>NONE</i>				19A. DATE OF OPERATION <i>NONE</i>					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> <i>1971</i> to <i>9/18</i> <i>1971</i> that (I) <i>(we)</i> last saw the deceased alive on <i>9/18</i> <i>1971</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.									
23A. SIGNATURE <i>Karl R. Meach, M.D.</i>				23B. DATE SIGNED <i>9/19/71</i>					
23C. PHYSICIAN'S NAME (Type) <i>Karl R. Meach, M.D.</i>				23D. ADDRESS <i>Pasadena, Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/22/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Co Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>McCallister, M.D. & Tuck, M.D.</i>		ADDRESS <i>Pasadena, Md</i>			



CERTIFICATE OF DEATH

REG. NO. 71

8969

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Albert C. Thurmond, Sr.

2. DATE AND HOUR OF DEATH

9/21/71

2:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastefn Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5019 E. Oliver Street 21205

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3/9/07

9. AGE (In years
last birthday)

64 yrs

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Feilding L. Thurmond

14. MOTHER'S MAIDEN NAME

Sarah E. Smith

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH Records -Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Probable Acute Myocardial Infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

A.S.C.V.D.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1/2 hour

10 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

C.O.L.D (Severe Bullous Emphysema). 20 yrs.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1/7/70 19 to 9/21/71 19
that (we) last saw the deceased alive on 9/21 19 71 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

W. L. Ramseur

M.D.
DEGREEAttending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

9/21/71

23C. PHYSICIAN'S
NAME (Type)

W. L. RAMSEUR

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/27/71

24C. NAME OF CEMETERY or CREMATORY

Horse Cave Cemetery

24D. LOCATION

(City, town, or county)

(State)

Hart Co. Horse Cave, Kentucky

25A. DATE REC'D BY HEALTH DEPT.

SEP 27 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

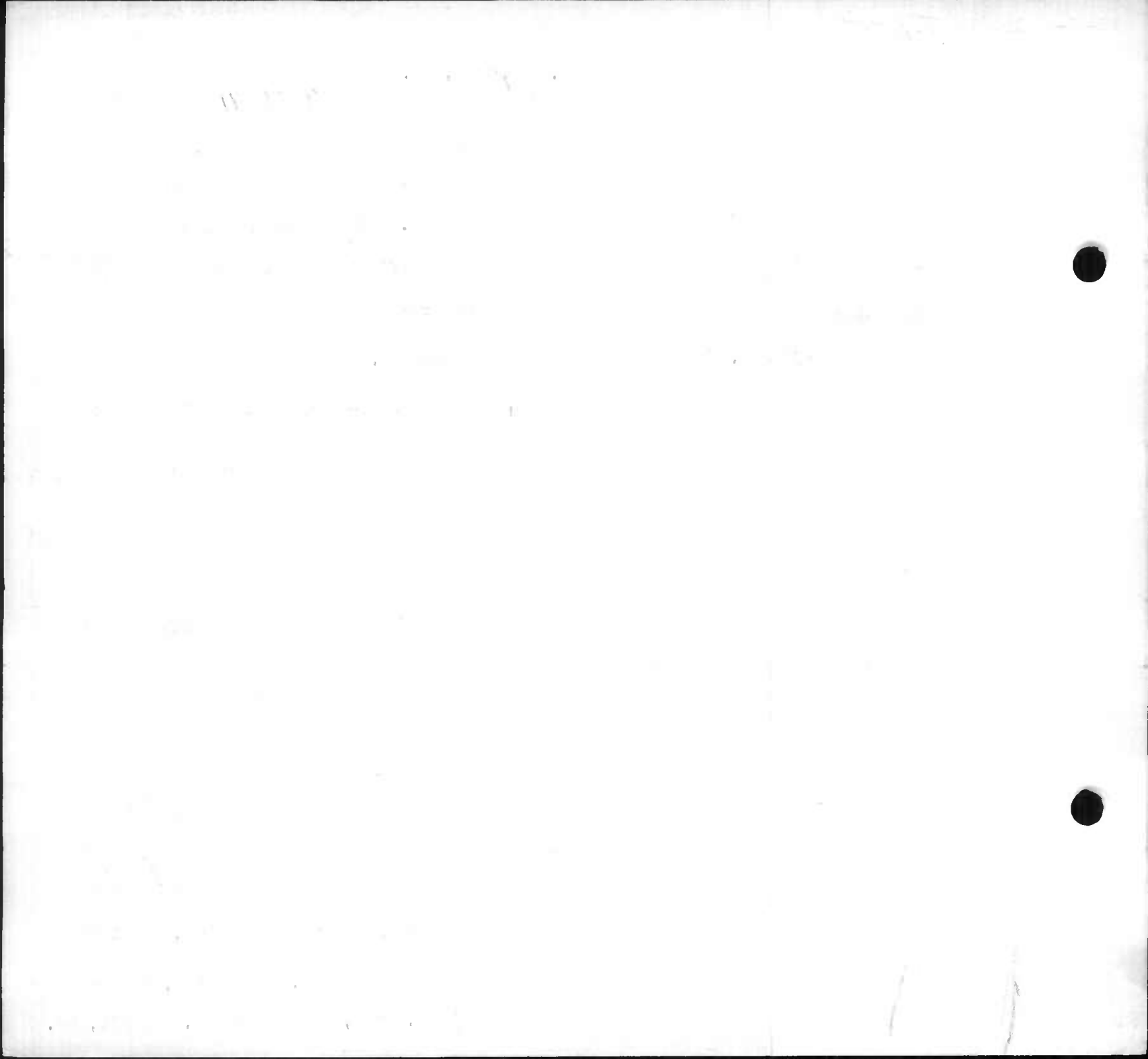
John J. Duda

ADDRESS

7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

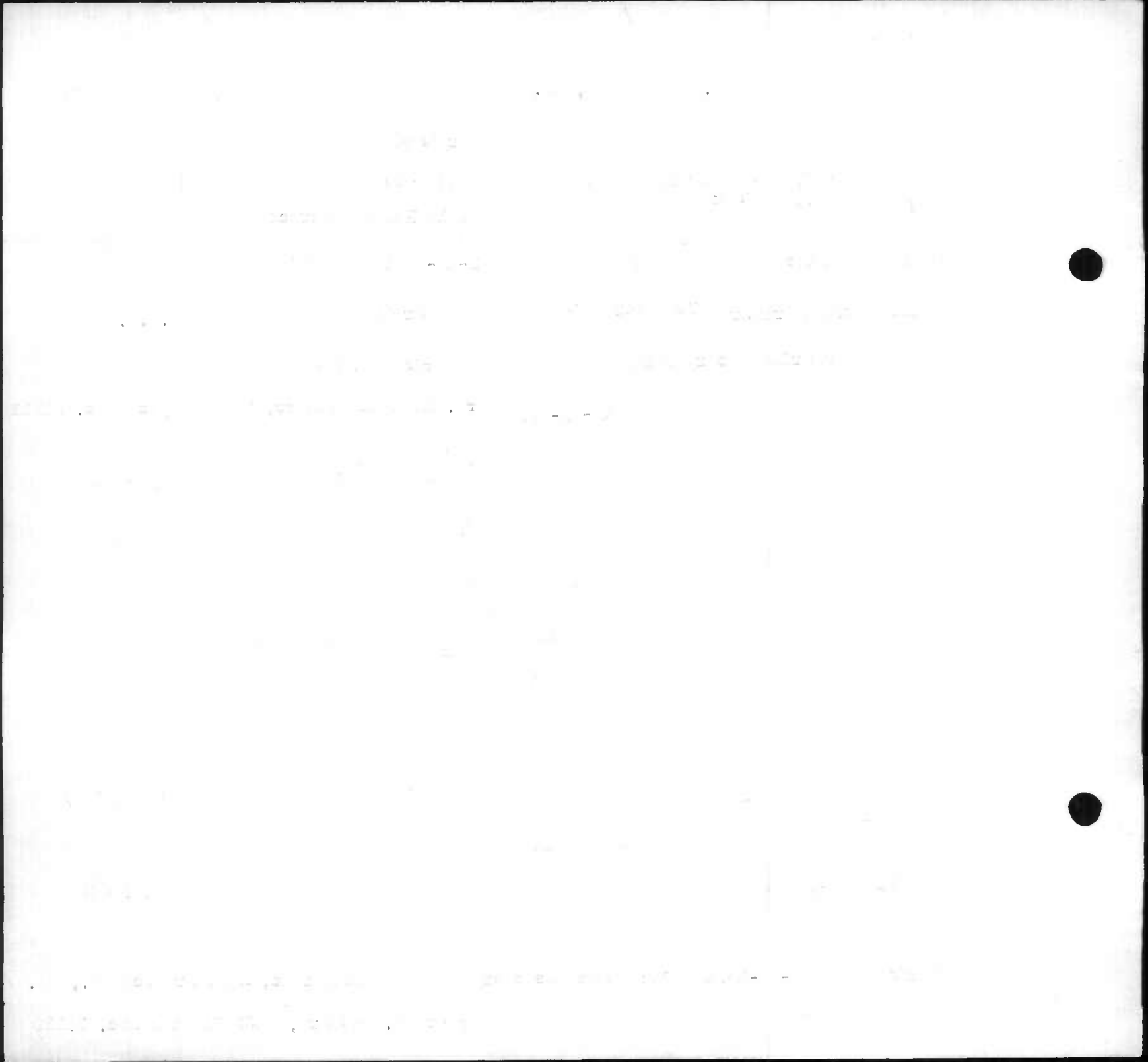
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

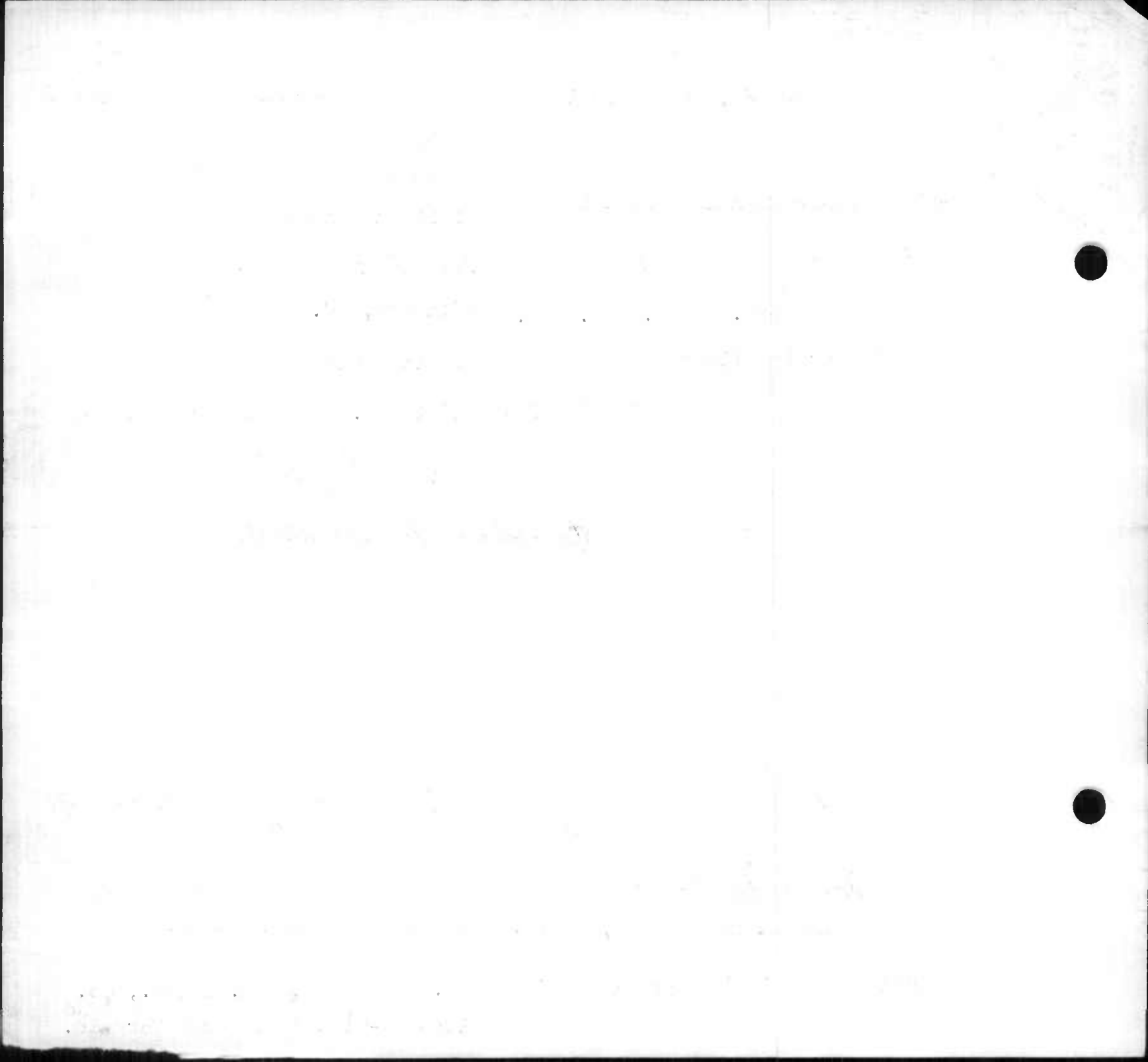
BALTIMORE CITY HEALTH DEPARTMENT				71 8970		71 8970	
CERTIFICATE OF DEATH				BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) William L. Farlow, SR.				2. DATE AND HOUR OF DEATH 9/22/71 5:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium Home 6116 Belair Road				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2003 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1911 Hollins Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1901		9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Driver			10B. KIND OF BUSINESS OR INDUSTRY Teamster Union		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Henry Farlow				14. MOTHER'S MAIDEN NAME Dola Bailey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-7779		17. INFORMANT ADDRESS Mrs. Lucille Steiner, 2807 Hampden Ave. 21211			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF: Chronic Pulmonary Emphysema (C) Chronic Pulmonary Emphysema Obstructive Pulmonary Disease; Chronic Bronchitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (He) attended the deceased from 9/15/71 to 9/22/71 that (I) (we) last saw the deceased alive on 9/17/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Albert D. Dondley				23B. DATE SIGNED 9/22/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-1971		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8971</u>	
BIRTH NO. <u>G-456 71 8971</u>					
1. NAME OF DECEASED (Type or Print) <u>GILNER, Marie Julia</u>				2. DATE AND HOUR OF DEATH <u>9/22/71</u> <u>6:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>901</u>	
				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3838 The Alameda</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/13/04</u>	9. AGE (in years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Serv.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Soc. Sec. Adm.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>XXH Augusta Klicka</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lavicka</u>	
16. SOCIAL SECURITY NO. <u>216 28 8734</u>				17. INFORMANT <u>William T. Parr</u> ADDRESS <u>3838 The Alameda</u>	
18. <u>4439 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Peripheral Vascular insufficiency</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/22/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>9/22/71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(this hospital)</u> attended the deceased from <u>9/18/71</u> to <u>9/22/71</u> and that <u>(I)</u> last saw the deceased alive on <u>9/22/71</u> and that <u>(my)</u> was opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. D. Hollenberg</u>				23B. DATE SIGNED <u>9/22/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Morley D. Hollenberg, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/24/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem.</u>	
24D. LOCATION <u>Padonia Rd. Balto., Co.</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld</u> ADDRESS <u>Md 6500 York Rd.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Donald Johnson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 25 Year 71 Hour 5:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 25 Year 71 Hour 5:40 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1603	
9. DATE OF BIRTH MARCH 17-1946		10. AGE (in years last birthday) 31	
11. BIRTHPLACE (State or foreign country) MILWAUKEE WIS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LUNICE JOHNSON		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME MAMIE YOUNG		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO. 255-60-1002		18. INFORMANT SHIRLEY JOHNSON 624 N Mount St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Gilmore & Edmondson Avenue 1603		22D. TIME OF INJURY (APPROX.) 9 24 71 11:00 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject stabbed during altercation.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/71	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Hanshan K. Hwang		25D. ADDRESS 1311 E. Baltimore St	

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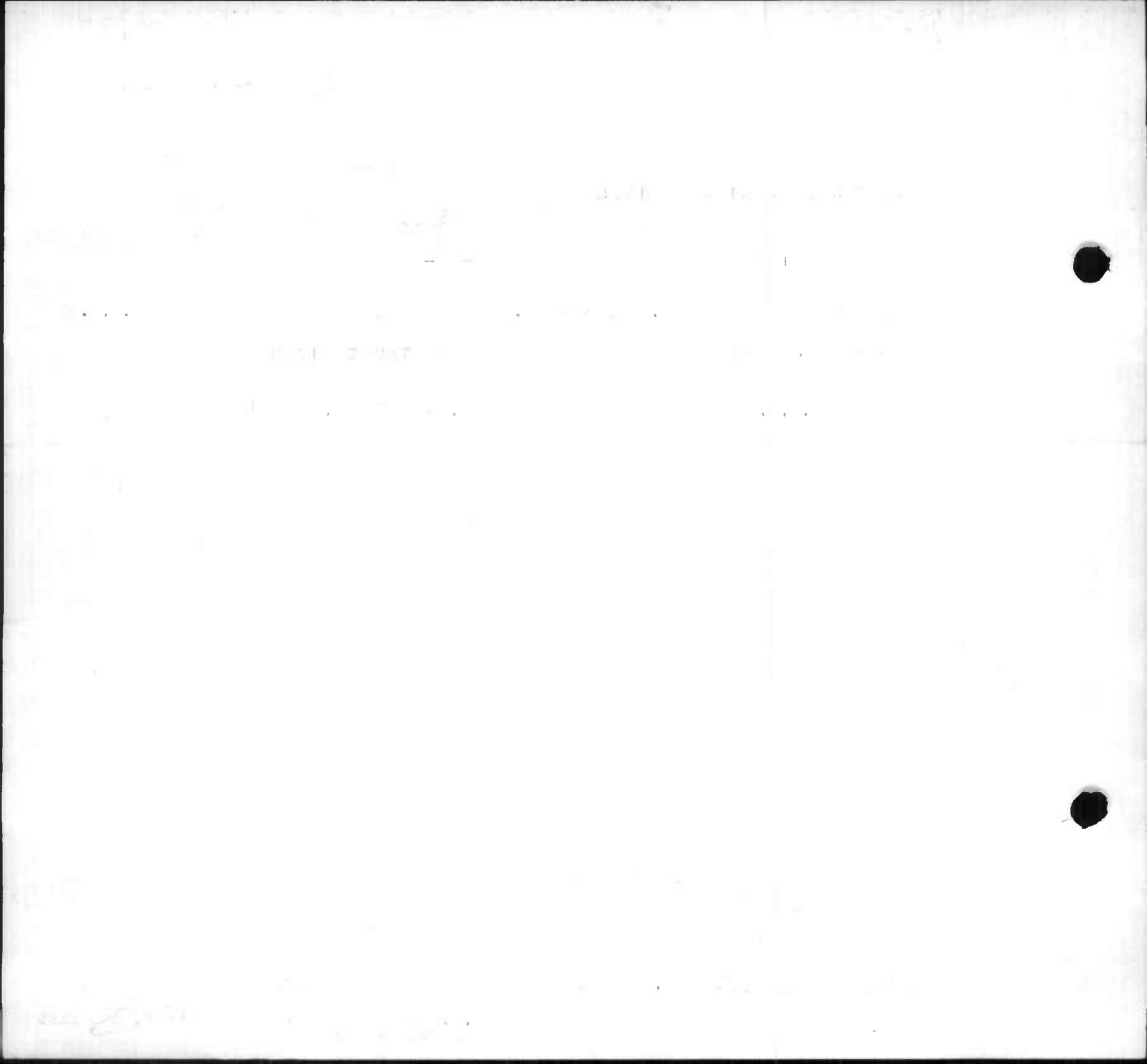
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-500		71 8973		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 8973	
BIRTH NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Alfred Denn</u>				2. DATE AND HOUR OF DEATH <u>9/22/71 15:55 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Fred.</u>					
				C. CITY OR TOWN <u>FREDERICK</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
				E. STREET AND NUMBER <u>406 LEE PLACE</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-09-20</u>		9. AGE (In years last birthday) <u>51</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Fred. Equipment Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED C. DENN</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE BISER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes U.S.N.</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Delories B. Denn (Same as above)</u>			
				ADDRESS					
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Surgery</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hr.</u>	
				(B) <u>ASCVD c.p.M.I.</u>				<u>5 yr.</u>	
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>1/9/22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Vertebral Column + MF</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>20 Sept 1971</u> to <u>22 Sept 1971</u> that (I) (we) last saw the deceased alive on <u>22 Sept 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Harry Koep</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>22 Sept 71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Larry Koep</u> M.D. DEGREE				23D. ADDRESS <u>J.H.H.</u>					
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/25/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Frederick Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>M.R. Etchison & Son Funeral Home, 106 East Church Street</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8974	
T-460 71 8974				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		TAYLOR, HERMAN M		2. DATE AND HOUR OF DEATH SEPTEMBER 23, 1971 NOON 12:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 6120 Edmondson Ave.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/09/96	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHEET METAL SIGN CO			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WORKER THEODORE TAYLOR			14. MOTHER'S MAIDEN NAME HENRIETTA FOWLER TAYLOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217-09-1626	17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS		
18. CAUSE OF DEATH 207.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute LEUKEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 15 19 71 to SEPTEMBER 23 19 71 that (I) (we) last saw the deceased alive on SEPTEMBER 23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lorato A. Vargas Jr. M.D.				23B. DATE SIGNED 9-23-71	
23C. PHYSICIAN'S NAME (Type) Dr. L. Vargars, Jr.		23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/71		24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Elkridge, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			
25B. NAME OF REGISTRAR L. J. ...		25C. FUNERAL DIRECTOR Macnabb & Sons ADDRESS 21228			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8975	
CERTIFICATE OF DEATH				REG. NO. 71 8975	
BIRTH NO. 8-530 71 8975					
1. NAME OF DECEASED (Type or Print) PEARL SMITH			2. DATE AND HOUR OF DEATH 22 Sept 71 2 20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSP. BALT, MD.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 623 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2230 E. FAIRMOUNT AVE.		
5. SEX ♀	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX 9/9/23		9. AGE (in years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Old Line Candy Co.		11. BIRTHPLACE (State or foreign country) Erwin, Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME H. CLAY HAMPTON			14. MOTHER'S MAIDEN NAME ETHEL TIPTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 415-36-8767		17. INFORMANT Mr. Howard Ray Smith 2230 Fairmount Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR FIBRILLATION (B) HYPOXIA & HYPOXEMIA DUE TO, OR AS A CONSEQUENCE OF: (C) LYMPHANGITIC CARCINOMA		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN 48 hrs 6-8 MONTHS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 26 Sept 1971 to 22 Sept 1971 that (I) (we) last saw the deceased alive on 22 Sept 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Keith L. Klein M.D.			23B. DATE SIGNED 22 Sept 71		
23C. PHYSICIAN'S NAME (Type) KEITH L. KLEIN			23D. ADDRESS Johns Hopkins Hosp BALT MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/26/71		24C. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	
24D. LOCATION (City, town, or county) (State) Erwin, Tenn.					
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.	

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11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

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31. 32. 33. 34. 35. 36. 37. 38. 39. 40.

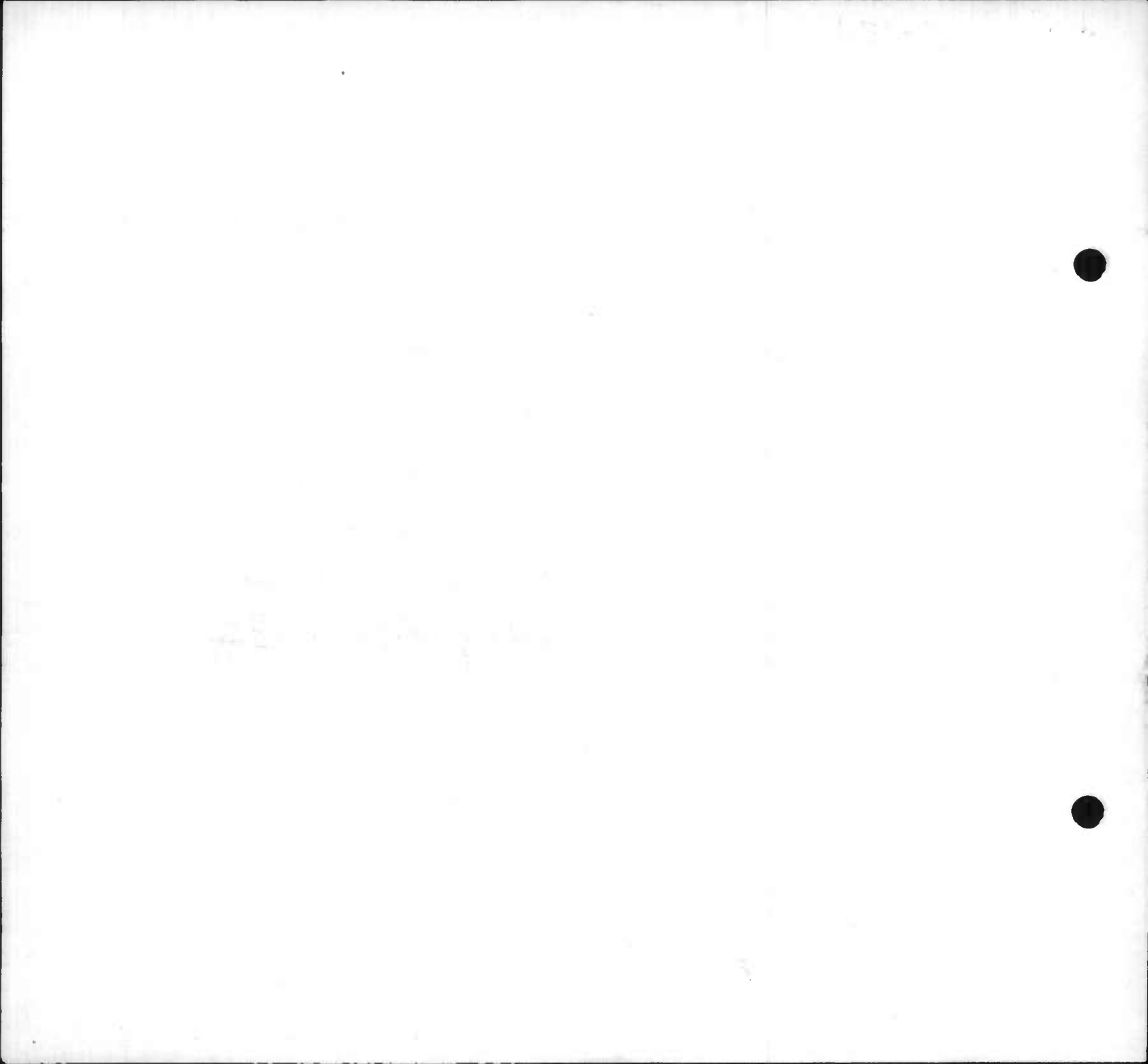
41. 42. 43. 44. 45. 46. 47. 48. 49. 50.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 71 8976		BALTIMORE CITY HEALTH DEPARTMENT		71 8976	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) HELEN BARRETT		2. DATE AND HOUR OF DEATH 9-23-71 12:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 102			
FULL NAME OF HOSPITAL OR INSTITUTION MD. GEN HOSP		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3029 E. BALTO ST		21224	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-00	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Heller Mfg.		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME Charles Souder		14. MOTHER'S MAIDEN NAME Margaret Wagner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-2411		17. INFORMANT CHART	
18. 4124 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro-Vase Accident (B) ASUVD DUE TO, OR AS A CONSEQUENCE OF: Rheumatic Heart Disease (C) Hypothyroid (benzocaine effusion)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9-21-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-21-71 to 9-23-71 and that (I) (we) last saw the deceased alive on 9-21-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sherman Kahan		23B. DATE SIGNED 9/23/71			
23C. PHYSICIAN'S NAME (Type) SHERMAN KAHAN		23D. ADDRESS MD GEN HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR John H. Morgan, Inc.	
25D. ADDRESS 3000 E. Baltimore St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 8977</u>	
1. NAME OF DECEASED (Type or Print) YEATMAN, ELEANOR C		2. DATE AND HOUR OF DEATH SEPTEMBER 22, 1971 12:56P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN SEVERNA PARK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 810 TEAKWOOD DR.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/03/93	9. AGE (In years last birthday) 78	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY @ home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL MC CLELLAN			
14. MOTHER'S MAIDEN NAME ALICE WHITE MC CLELLAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			
16. SOCIAL SECURITY NO. 212-07-2492		17. INFORMANT ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe Peritonitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diverticulitis and bleeding and lost operation for sigmoid resection			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/18/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED bleeding diverticulum		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 18 19 71 to SEPTEMBER 22 19 71 that (I) (we) last saw the deceased alive on SEPTEMBER 22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Wynn				23B. DATE SIGNED 09/22/71	
23C. PHYSICIAN'S NAME (Type) JESADA MUANGSOMBUT M.D.				23D. ADDRESS ST. Agnes' Hosp.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/25/71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) Woodlawn Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Barbara Severna Park			

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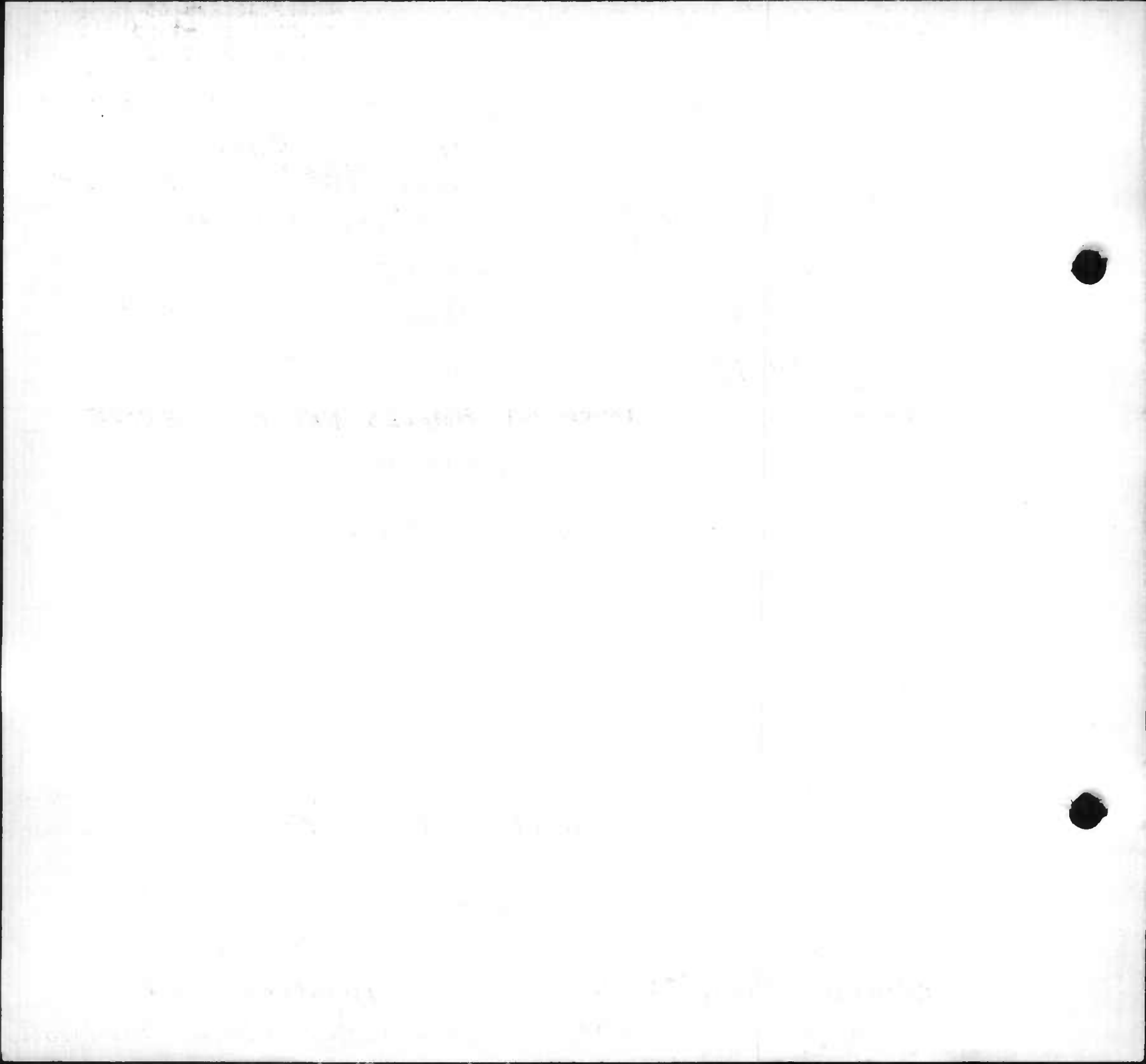
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

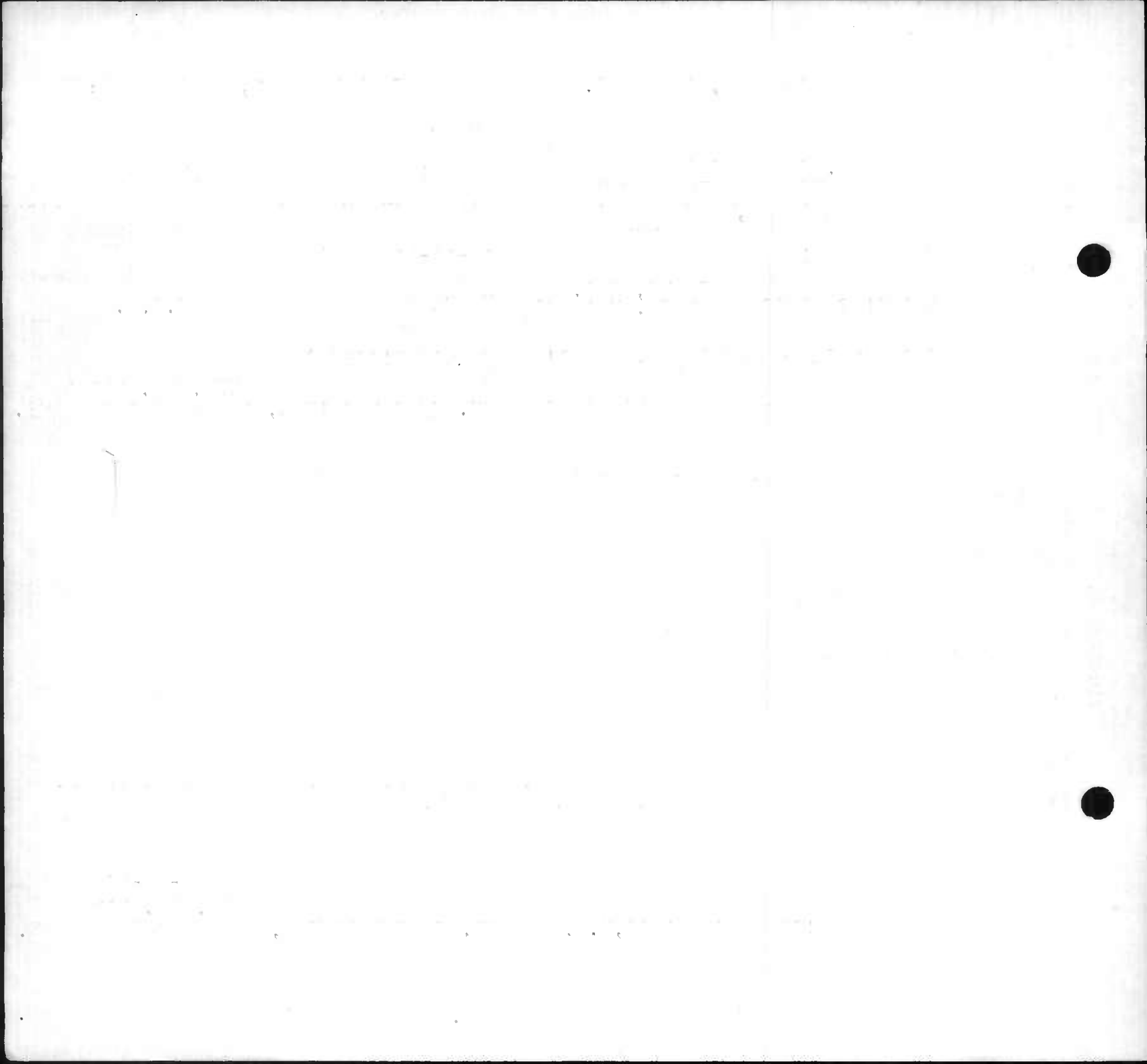
<div style="display: flex; justify-content: space-between;"> K-610 71 8978 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		KREPP, JOSEPH 65 8978 DR. HULL 36-44-23 REG. NO. DR. GRAHAM RC S	
1. NAME OF DECEASED (Type or Print) KREPP, Joseph Michael		2. DATE AND HOUR OF DEATH 23 Sept 1971 645 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		C. CITY OR TOWN ESSEX Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2214 Consta Rd 21221					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-05	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Krepp		14. MOTHER'S MAIDEN NAME Anastasia Mohr			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 170-03-7929		17. INFORMANT FRANCES KREPP	
18. 15411 I		CAUSE OF DEATH		ADDRESS Above	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Obstructive uropathy		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Carcinoma rectum DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/17 19 71 to 9/23 19 71 that (1) (we) last saw the deceased alive on 9/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor J. Rogosa MD		23B. DATE SIGNED 9/23/71			
23C. PHYSICIAN'S NAME (Type) VICTOR J. ROGOSA		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	24B. DATE 9/24/71	24C. NAME OF CEMETERY or CREMATORY CALVARY		24D. LOCATION (City, town, or county) (State) PITTSBURG PA	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Connolly Funeral Home	
				ADDRESS 300 Main Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

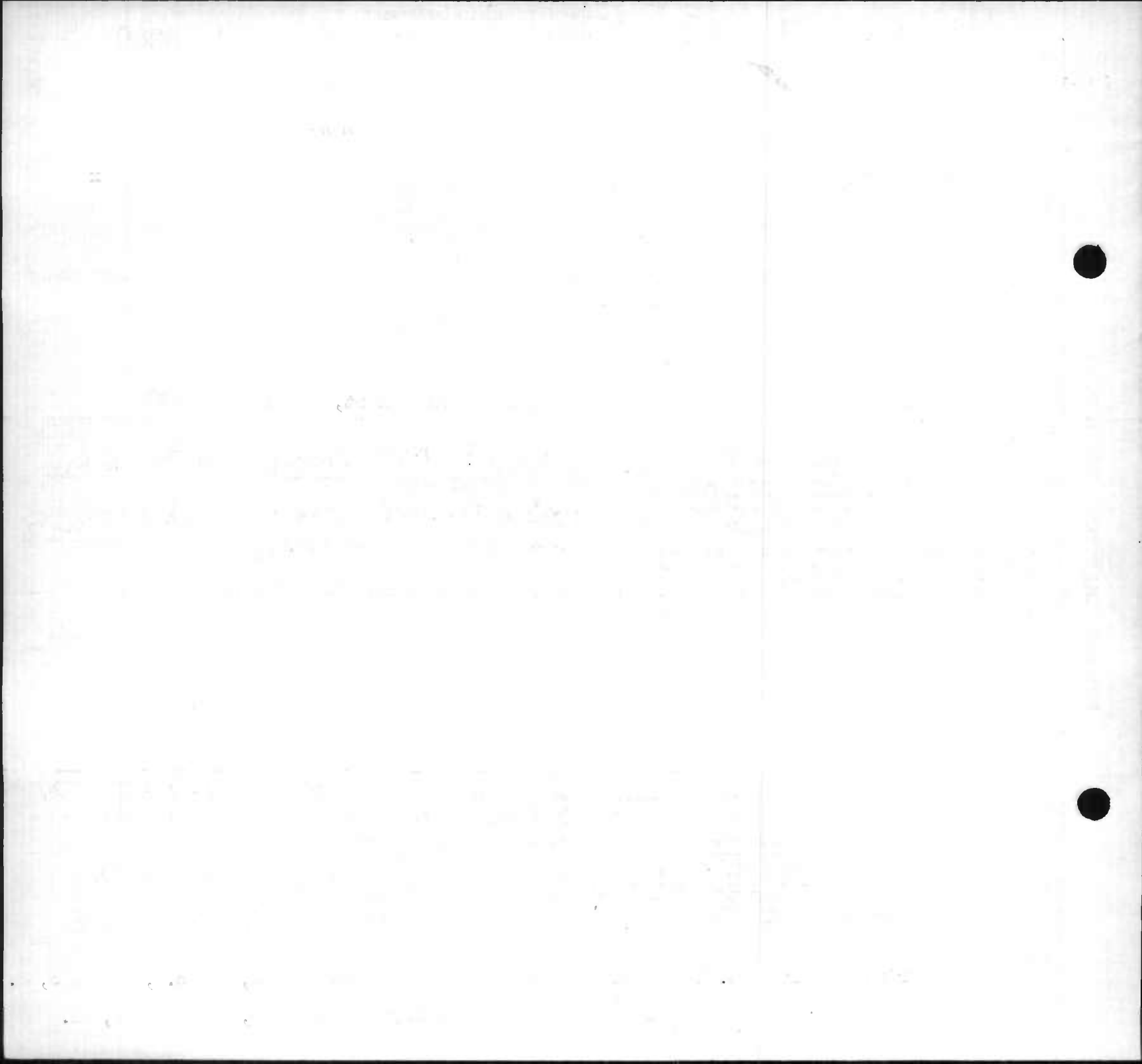
<div style="display: flex; justify-content: space-between;"> 7-453 71 8979 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>71 8979</u>	
BIRTH NO. <u>71 8979</u>		1. NAME OF DECEASED (Type or Print) <u>FLANDORFFER, WILLIAM G.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>WILKENS & CATON AVENUE</u> <u>BALTIMORE, MARYLAND 21229</u>		2. DATE AND HOUR OF DEATH <u>SEPTEMBER 22, 1971</u> <u>10:50 P.</u> 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2005</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>429 EAST LYNN AVENUE</u> <u>21229</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-21</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTING PRESSMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FORMS, INC. BALTO. BUSINESS</u>	9. AGE (In years last birthday) <u>49</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GUSTAVE FLANDORFFER</u>		14. MOTHER'S MAIDEN NAME <u>NELLIE (FISCHER)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1942-1945</u>		16. SOCIAL SECURITY NO. <u>216148058</u>	
17. INFORMANT <u>BALTO. MD. 21229</u>		ADDRESS <u>ST. AGNES HOSPITAL, WILKENS & CATON AVE.</u>	
18. <u>2005-7-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Granulocytic Leukemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 15</u> 19 <u>71</u> to <u>SEPTEMBER 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>SEPTEMBER 22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Victor Benavides</u>		23B. DATE SIGNED <u>09-22-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>VICTOR BENAVIDES, M.D.</u>		23D. ADDRESS <u>BALTO. MD. 21229</u> <u>ST. AGNES HOSPITAL, WILKENS & CATON AVE.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/25/1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>	25B. NAME OF REGISTRAR <u>Robert A. Taylor</u>	25C. FUNERAL DIRECTOR <u>W. Thomas Schwab</u>	ADDRESS <u>3512 Frederick Ave.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
C-416 71 8880				REG. NO. 71 8880	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CALVERT ANNIE</u>				2. DATE AND HOUR OF DEATH <u>9-23-71</u> <u>1 9¹⁹</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>				A. STATE <u>MARYLAND</u> <u>111</u> B. COUNTY <u>5200</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>PASADENA</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER <u>RT. 2 Box 325</u>	
8. DATE OF BIRTH <u>1-7-90</u> 9. AGE (in years last birthday) <u>81</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MO</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY ALFRED COOK</u>				14. MOTHER'S MAIDEN NAME <u>RHODA V. HANCOCK</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-10-1034-B</u>	
17. INFORMANT <u>James Calvert, same as 4</u>				ADDRESS	
18. <u>410.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYOCARDIAL INFARCTION 16 hrs.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HYPER TENSIVE CARDIO-VASCULAR 9 years.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>9 years.</u>	
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-23-1971</u> to <u>9-23-1971</u> that (I) (we) last saw the deceased alive on <u>9-23-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harjit Singh M.D.</u>				23B. DATE SIGNED <u>9-23-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARJIT SINGH</u>				23D. ADDRESS <u>3001 S. HAMOVER ST. BALTIMORE.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>26 Sept. 71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Magothy Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Jacobsville, AA Co., Pasadena, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>				25B. NAME OF REGISTRAR <u>0 0 0</u>	
25C. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8981
REG. NO. 71 8981

C-462 71 8981

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Rouben L. Clark Rubin Clark		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 26 71 12:20 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 26 71 12:20 a.m.			
6. SEX male		7. RACE Negro		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1510	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5/28/19		10. AGE (In years last birthday) 52		E. STREET AND NUMBER 3908 Pennhurst Avenue	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Eleanora	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-07-8935		18. INFORMANT ADDRESS Mildred M. Clark 1652 N. Monroe St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 932 Franklin Town Road 1606	
22D. TIME OF INJURY (APPROX.) 9 25 71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot by girlfriend during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/71		24C. NAME OF CEMETERY or CREMATORY Auburn Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Annapolis & Hollins Md.		24E. FERRY RD. Ferry Rd.			
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.	

V.S. 151-REV. 1/1/68

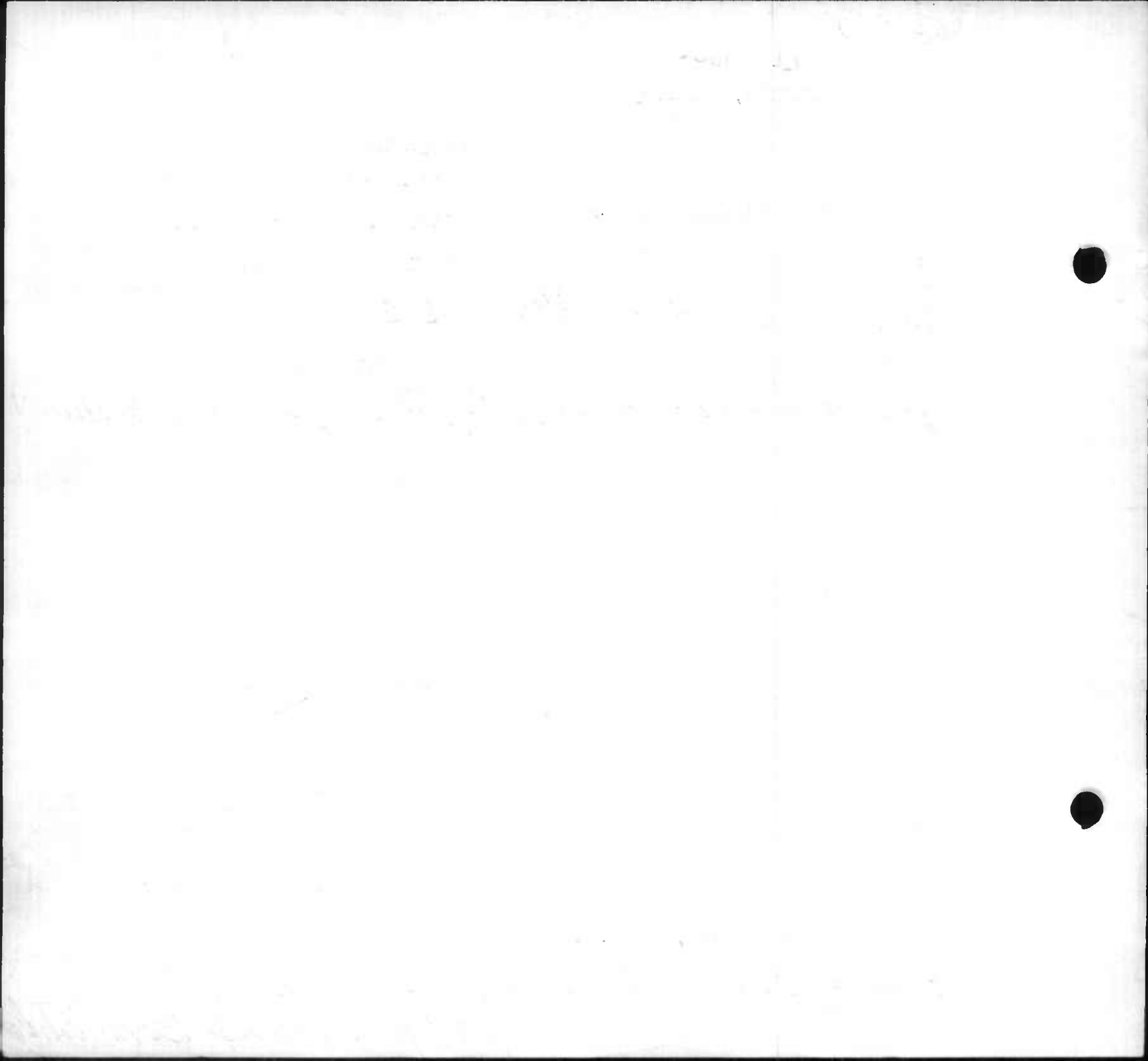
9/30/71 - Correction form from funeral director.

APC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-200		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 8982	
BIRTH NO. 71 8982		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GASQUE, Westley		2. DATE AND HOUR OF DEATH <i>Sept. 23, 1971</i> 7:05 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1705 E. Madison Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/34	9. AGE (In years last birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wire Drawer Beth Steel</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Gasque		14. MOTHER'S MAIDEN NAME Dora Wilson			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 12/56 - 1/58		16. SOCIAL SECURITY NO. 247-48-1515		17. INFORMANT ADDRESS <i>Luzette Gasque 1705 E. Madison St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>MYOCARDIAL INFARCTION</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>CARCINOMA OF COLON</i>			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.P.R.O.X.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>SEPT 23</i> 19 <i>71</i> to <i>SEPT 23</i> 19 <i>71</i> that (I) (we) lost saw the deceased alive on <i>SEPT 23</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James T. Martin, M.D.</i>		23B. DATE SIGNED 9-23-71		23C. PHYSICIAN'S NAME (Type) James Martin, M.D.	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Removal</i>		24B. DATE 9/26/71		24C. NAME OF CEMETERY OR CREMATORY <i>White Hill Memory Garden D.C.</i>	
24D. LOCATION (City, town, or county) (State) D.C.		25A. DATE RECEIVED BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR <i>Joseph V. Locks</i>	
25C. FUNERAL DIRECTOR <i>Joseph V. Locks</i>		ADDRESS <i>1304 N. Central</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. D-450 71 8983					REG. NO. 71 8983				
1. NAME OF DECEASED (Type or Print) Dillon, Fiona					2. DATE AND HOUR OF DEATH 9-17-71 8:10 p.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Pleasant Manor N.H.					A. STATE MD.				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4615 Park Heights Ave. Baltimore Md.					B. COUNTY City				
					C. CITY OR TOWN Baltimore				
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 3304 Gwen Falls Pkwy.				
5. SEX F.		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/26/28		9. AGE (In years last birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory work					10B. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) TRINIDAD, W. I.					12. CITIZEN OF WHAT COUNTRY? West Indies				
13. FATHER'S NAME Moses Dillon					14. MOTHER'S MAIDEN NAME Estelle Clark Dillon (dec.)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 215-1560				
					17. INFORMANT Friend Layton, Kate				
					ADDRESS 3304 Gwen Falls Pkwy Baltimore, Md.				
18. 174 X I					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					Metastatic Breast Carcinoma				
ANTECEDENT CAUSES					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION None					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 10 Sept 1971 to 17 Sept 1971 , that (I) (we) last saw the deceased alive on 10 Sept 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert J. Wilensky MD					23B. DATE SIGNED 17 Sept 71				
23C. PHYSICIAN'S NAME (Type) Robert J. Wilensky MD					23D. ADDRESS 6210 Lymount Rd, Bact. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 9/21/71				
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971					25B. NAME OF REGISTRAR Kenneth Law				
25C. FUNERAL DIRECTOR 4280					ADDRESS 4611 Park Heights Ave.				

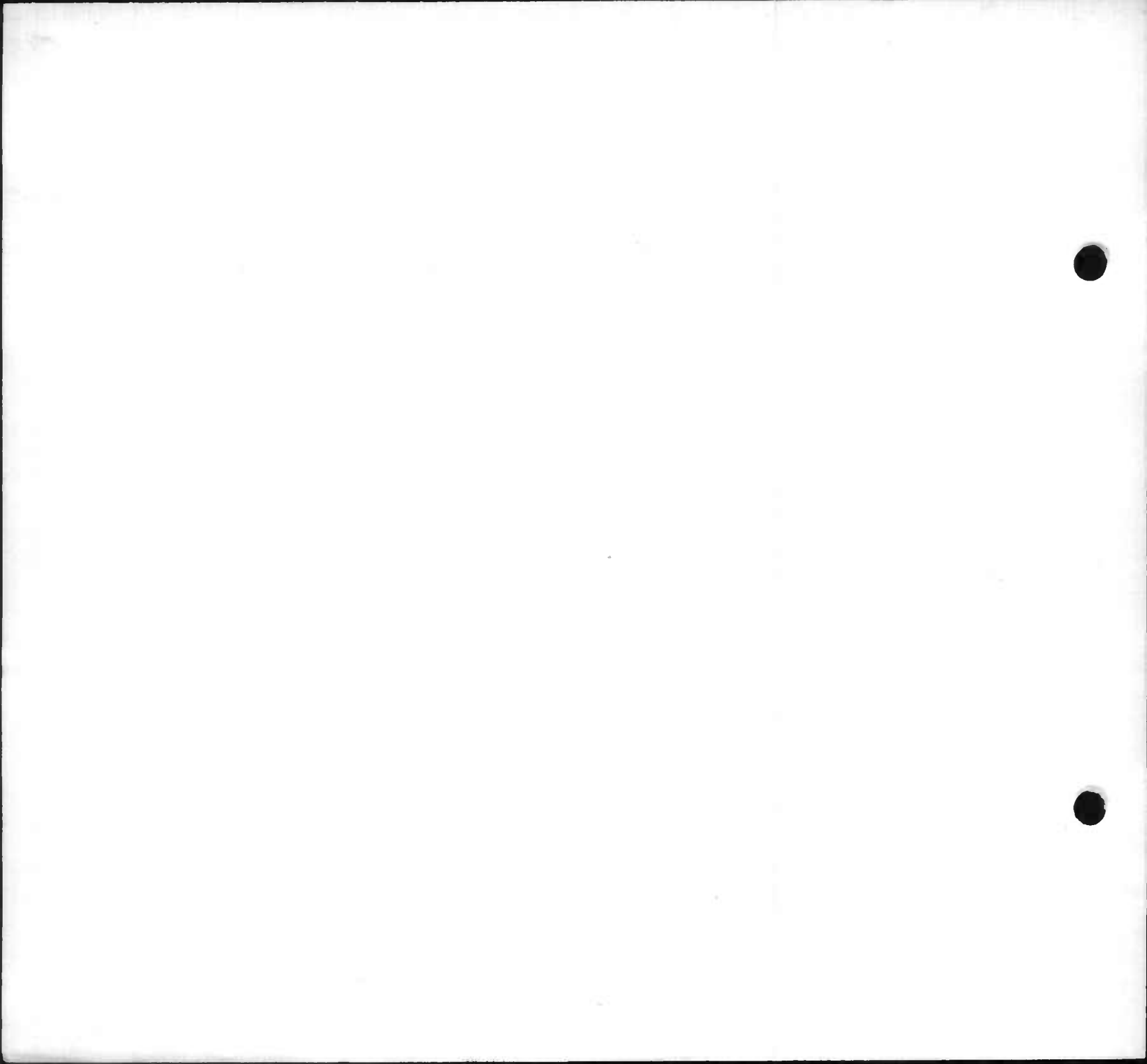
0-1-0-1

1711

FUNERAL DIRECTOR: IMPORTANT

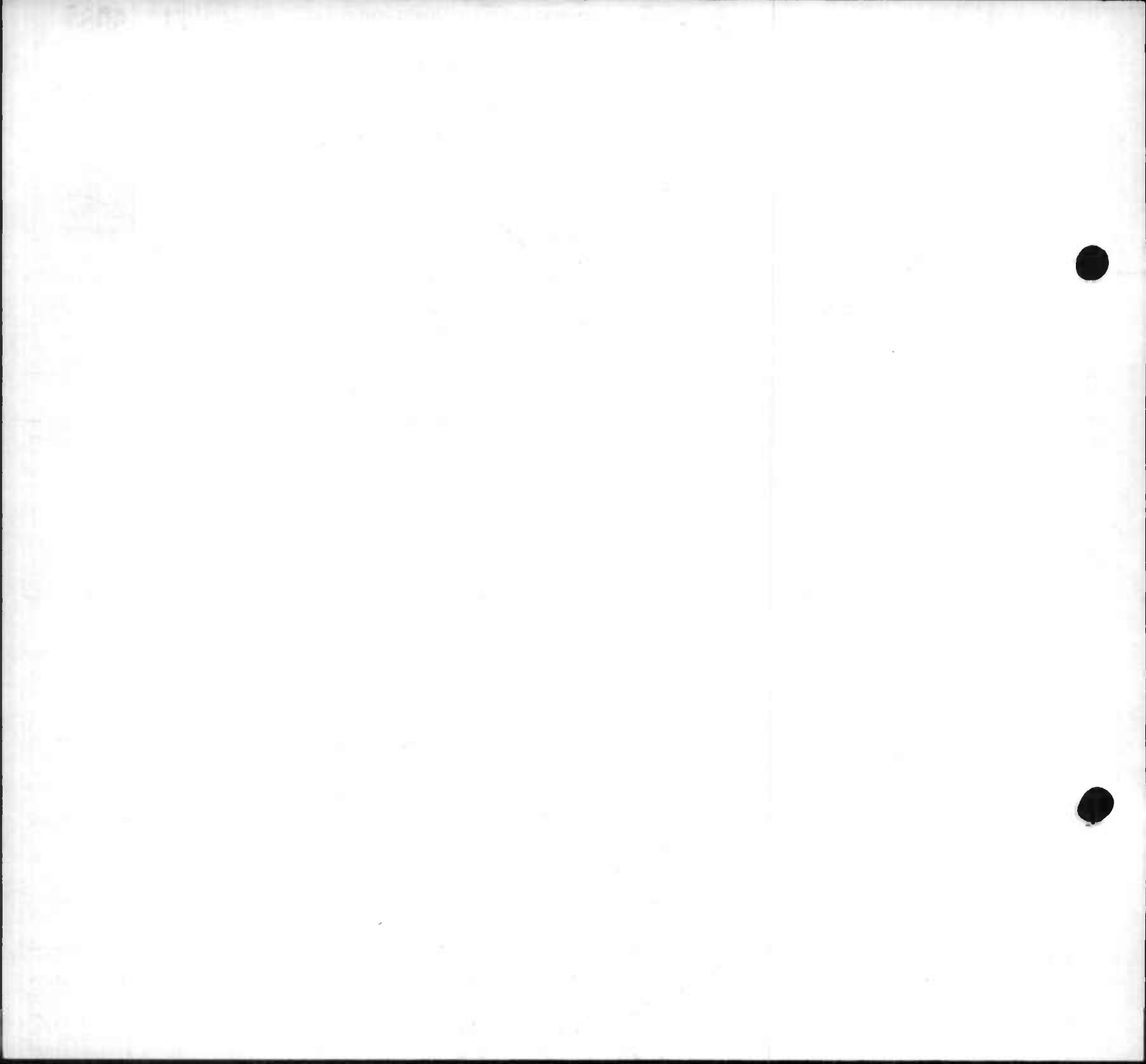
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-360 71 8984		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8984	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MR. Louis J. Della Pietra</i>		2. DATE AND HOUR OF DEATH <i>9-24-71 5:55 am.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> <i>Gayeth + Pulaski Sts., Balt., Md 21223</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>W.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-14-22</i>		9. AGE (In years last birthday) <i>49</i>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Ballentine Della Pietra</i>		14. MOTHER'S MAIDEN NAME <i>Mary Signorelli</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215 16 6081</i>		17. INFORMANT <i>from the front shut of chest.</i>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <i>Respiratory failure</i>		DUE TO, OR AS A CONSEQUENCE OF:		<i>more than 12 days</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) <i>as long as patient was.</i>		<i>unknown.</i>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>9-20-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Thoracic aortic</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 16-71</i> 19 <i>71</i> to <i>Sept. 24</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>9-23</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Maline Yunyonying</i>		M.D. DEGREE Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9-24-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>MALINE YUNYONYING</i>		23D. ADDRESS <i>M.D. BON SECOURS HOSPITAL, BALTIMORE, Md. 21223</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/27/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION <i>Balto. Md.</i>		24E. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1971</i>		25C. FUNERAL DIRECTOR <i>122 ANNINO FUR.</i>		ADDRESS <i>263 S. CONKLING ST</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 8985		8985	
CERTIFICATE OF DEATH				REG. NO.		71 8985	
1. NAME OF DECEASED (Type or Print)		KAVANAGH MISS ANNIE		2. DATE AND HOUR OF DEATH		4. A.M. 9/26/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F				6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-18-96		9. AGE (in years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home life Retail party worker		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME JOHN P. KAVANAGH		14. MOTHER'S MAIDEN NAME MARY BRAUM		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 218-50-5531		17. INFORMANT JOSEPH KAVANAGH 2003 E. PRATT ST.		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) Atherosclerosis.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Peripheral Vascular insufficiency			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Refused			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 9-7-71 to 9/26/71		that (I) last saw the deceased alive on 9/26/71		and that (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) view the body after death.			
23A. SIGNATURE T. Sree Ramamurthy				23B. DATE SIGNED 9/26/71			
23C. PHYSICIAN'S NAME (Type) T. SREE RAMAMURTHY				23D. ADDRESS CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/29/71		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.		24D. LOCATION 4430 BELAIR RD BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR DIPPE & BROS INC 1800 E LOMBARD ST		ADDRESS	



B6521

71 8986

BALTIMORE CITY HEALTH DEPARTMENT

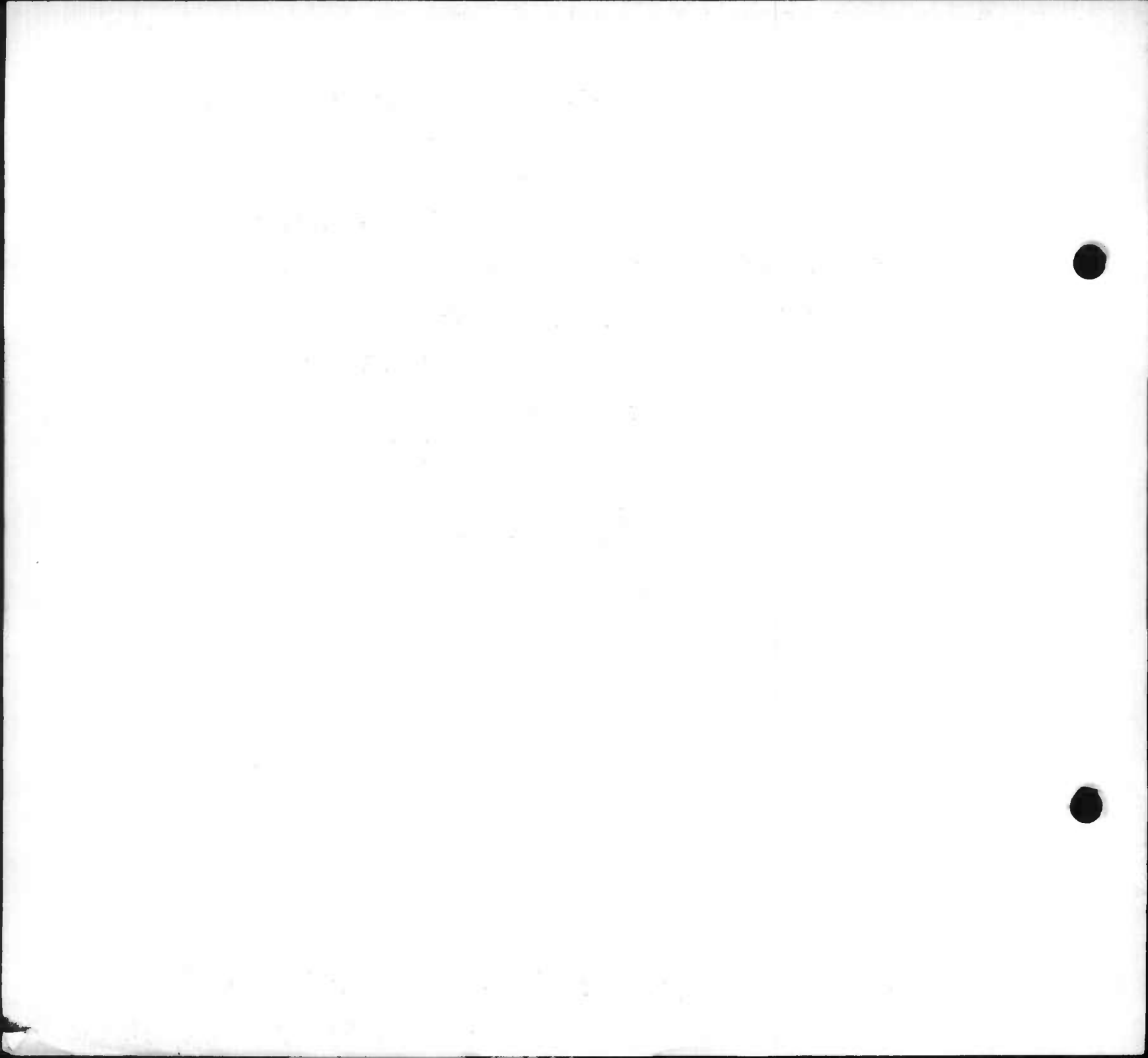
CERTIFICATE OF DEATH

REG. NO. 71 8986

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

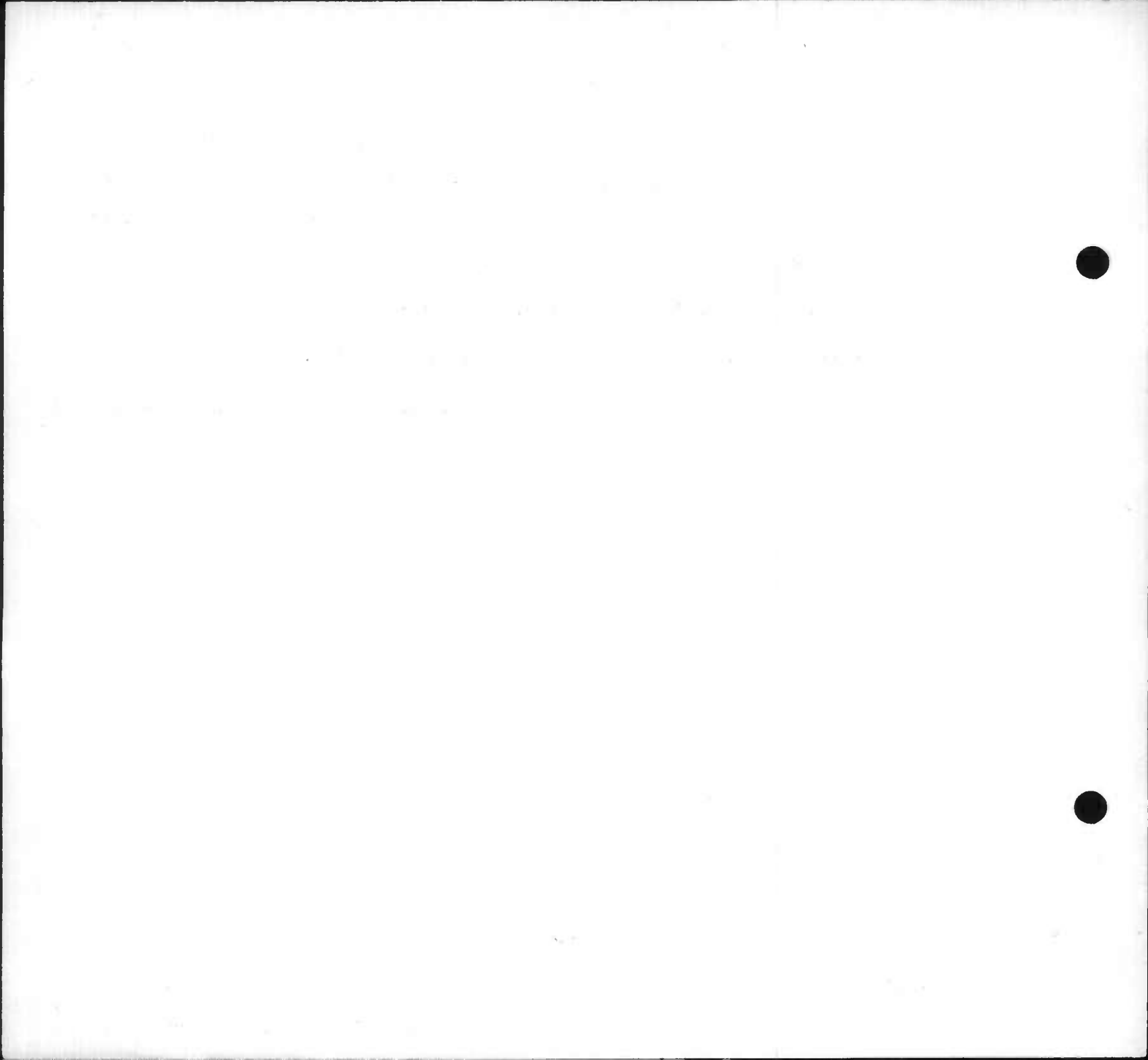
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mr. John Barrington</u>		2. DATE AND HOUR OF DEATH <u>Sept. 22, 1971</u> <u>8:45 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1901</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1637 W. Lexington St.</u>		5. SEX <u>MALE</u>		6. RACE <u>BLACK</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>06-19-09</u>		9. AGE (In years last birthday) <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>PETER Barrington</u>		14. MOTHER'S MAIDEN NAME <u>ROSS, Mary</u>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>712-09-1429</u>		17. INFORMANT <u>Patient's Chart</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> <u>Compression of Spinal Cord</u> <u>Card compression</u>		CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>4 days</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <u>9-16-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1637 W. Lexington St.</u>		21D. TIME OF INJURY (Approx.) <u>9:16.71</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell from chair</u>		22. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> 19 <u>71</u> to <u>9-22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Pulchra (19)</u>		23B. DATE SIGNED <u>9-22-71</u>		23C. PHYSICIAN'S NAME (Type) <u>PULCHRA</u>	
23D. ADDRESS <u>BON SECOURS HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>St. Calixtus Cem.</u>		24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. IS TOL	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home 3199 Schroeder St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 8987	
1. NAME OF DECEASED (Type or Print) STRIPPY, NORMAN			2. DATE AND HOUR OF DEATH 9/25 5:30		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BON SECOURS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 12 Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL			C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 1200 NWOOD DR.			21228		
5. SEX m	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind, or work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Moving Storage Bus.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME late Otto Strippy		14. MOTHER'S MAIDEN NAME late Annie E.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 27-03-2837		17. INFORMANT Mrs. Ruth Strippy 1200 Nuwood Drive 21228	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/25 19 71 to 9-25 19 71 that (I) (we) lost saw the deceased alive on 9-25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Masahiro Sugawara M.D.			23B. DATE SIGNED 9/25 1971		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) MASAHIRO SUGAWARA M.D.			23D. ADDRESS BON SECOURS HOSPITAL Balto. Md. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Buried	24B. DATE 9/29/71	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 8988	
L-100 71 8988				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Eugene B. Lappe, Sr.			2. DATE AND HOUR OF DEATH September 25, 1971 12 noon M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 723 Brinkwood Road 21229		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/193	9. AGE (in years last birthday) 78	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10B. KIND OF BUSINESS OR INDUSTRY B & O. R.R.	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME late Charles			14. MOTHER'S MAIDEN NAME late Catherine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Etta Lappe 723 Brinkwood Road 21229		
18. I 4107 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive Coronary (B) occlusion DUE TO, OR AS A CONSEQUENCE OF: A.S.C.U.D. (C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1969 to Sep 25 1971 that (I) (we) last saw the deceased alive on Sep 35 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas			23B. DATE SIGNED 9.27.71		23C. PHYSICIAN'S NAME (Type) Dr. Stanley Ankudas M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/29/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1530 Edmondson Avenue



71 8989

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 8989
REG. NO.

BIRTH NO.

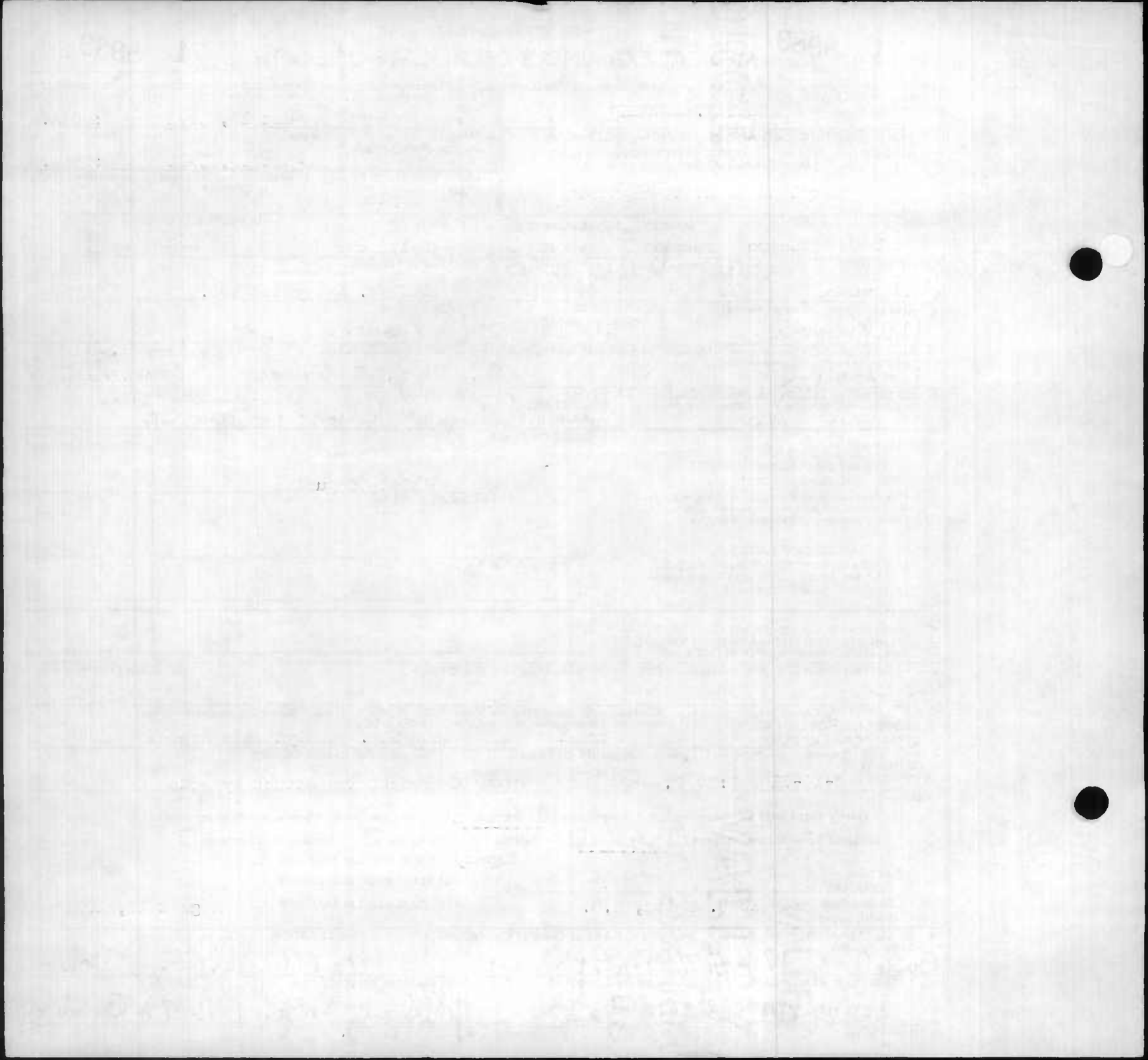
1. NAME OF DECEASED (Type or Print) BETTY M. TOWSEND		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 17, 1971 8:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 17, 1971 8:00 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1603	
9. DATE OF BIRTH Unknown		10. AGE (in years last birthday) 59	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Wilson	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		16. KIND OF BUSINESS OR INDUSTRY Unknown	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No		18. SOCIAL SECURITY NO. Unknown	
19. CAUSE OF DEATH Multiple injuries		19. ADDRESS 1603 E. Eutaw St.	

19. CAUSE OF DEATH Multiple injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:	
(B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION 8-16-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 100 blk. Pennsylvania Avenue	
22D. TIME OF INJURY (APPROX.) 8-16-71 2:10 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 17, 1971	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/24/71		24C. NAME OF CEMETERY or CREMATORY Int. Colony		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR William J. Spier		ADDRESS 1639 N. Broadway	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B4001

BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH

REG. NO. **71 8990**

BIRTH NO. **71 8990**

1. NAME OF DECEASED (Type or Print) Marie Bailey (MARIE J. BAILEY)		2. DATE AND HOUR OF DEATH 9-25-71 5:12 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore, Md. B. COUNTY 306 S. Lehigh St. 2607	
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-97 9. AGE (In years last birthday) 74 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY At Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Heath		14. MOTHER'S MAIDEN NAME Annie Gabler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT John F. Bailey : 306 S. Lehigh St., Balto., Md.		ADDRESS	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 h.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Insufficiency -	
		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD, CHF	
		(C) years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John Ohe MD		23B. DATE SIGNED 9/25/71	
23C. PHYSICIAN'S NAME (Type) John OHE MD		23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-71.	
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Bailey, MD.	
25C. FUNERAL DIRECTOR Charles L. Seiler		ADDRESS 6224 Eastern Ave. Balto., 21224, Md.	

A

71 8991

REG. NO. 71 8991

BIRTH NO.

REG. NO.

VS 151-REV. 7/1/68

1902

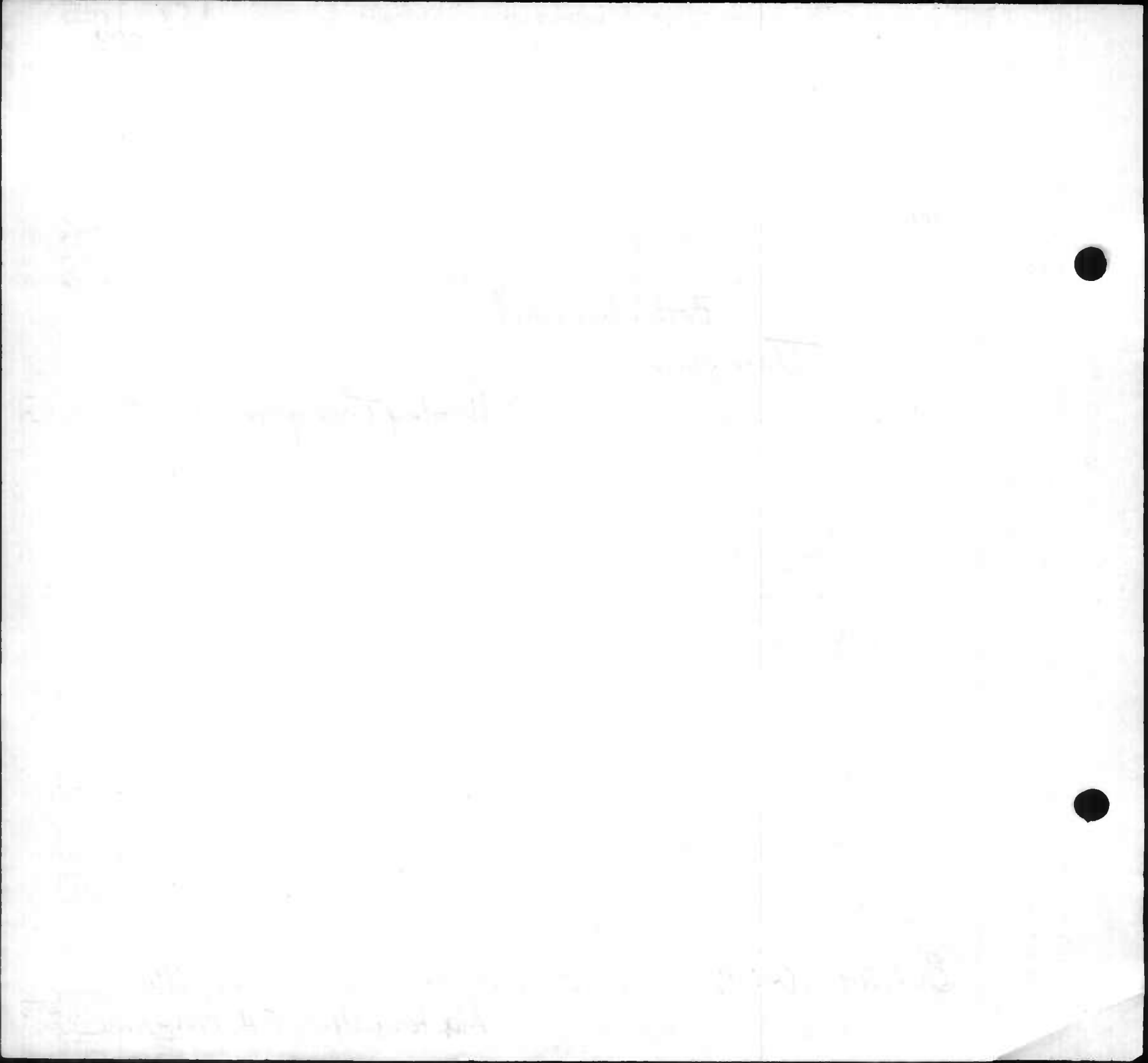
1902



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 8992</u>	
<div style="display: flex; justify-content: space-between;"> T-512 71 8992 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Im Thompson		9/26/71 2:43 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
South Baltimore General Hospital		Maryland - Baltimore City 1301			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		727 Druid Lake Drive		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days
M	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/22/90	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
factory worker		Bethlehem Steel		North Carolina	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charlie Thompson			Alice Hill		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown		210-10-4799A		Wesley Thompson - 4407 - Old York Rd.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prostatic Ca-metastasized 75 years					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no		none		NA.	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>September 21 19 71</u> to <u>September 26 19 71</u> that (I) (we) last saw the deceased alive on <u>September 26 19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Gwynne L. Horwits, M.D.				9/26/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Gwynne L. Horwits, M.D.				2007 Selgrave Ave, Baltimore, Md. 21209	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-1-71		Hebatus Memory, Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 27 1971		Robert E. Jones, Jr.		Wesley Thompson, 4407 Old York Rd., St. Lawrence	



D-32571

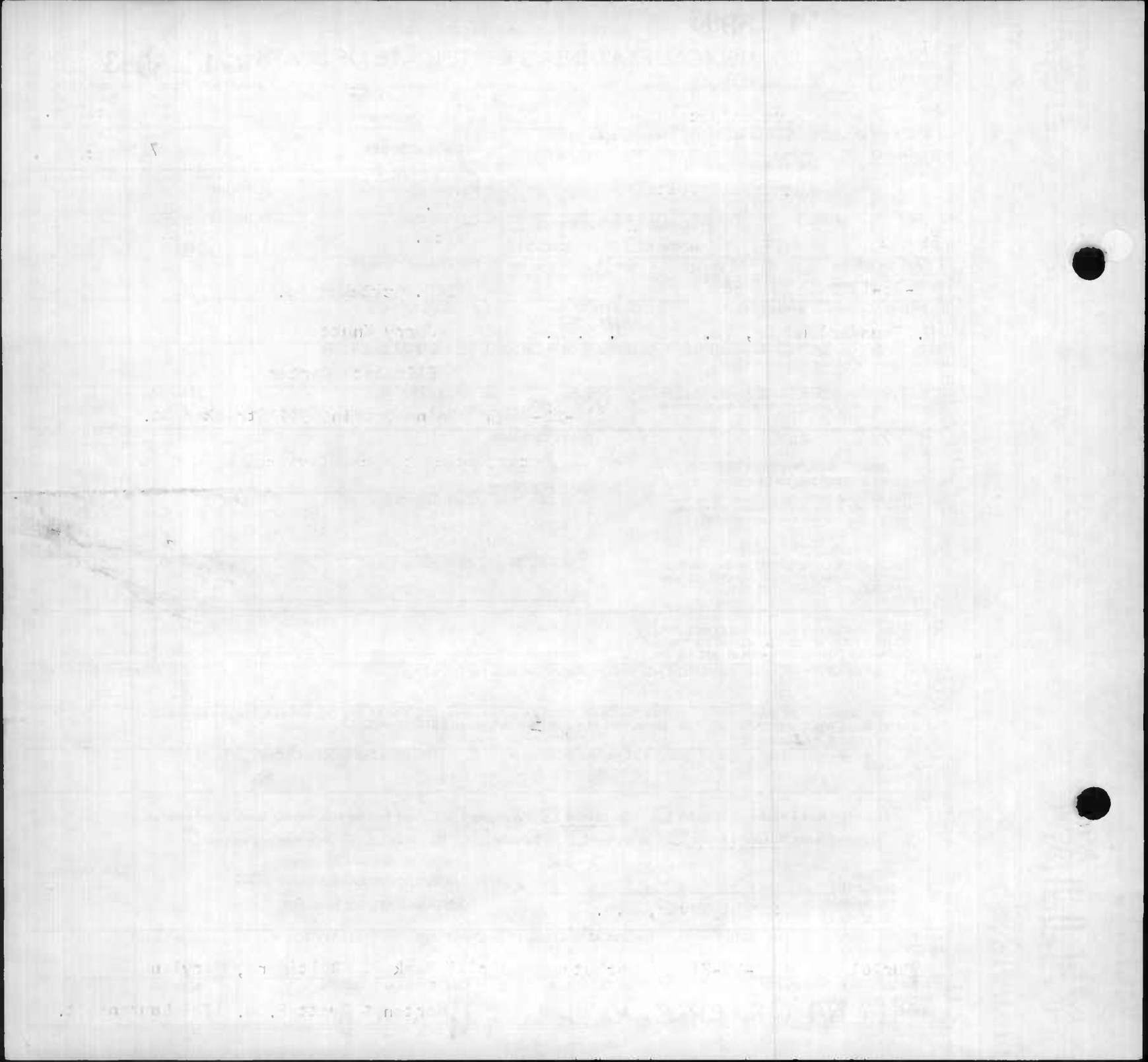
8993

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 71 8993

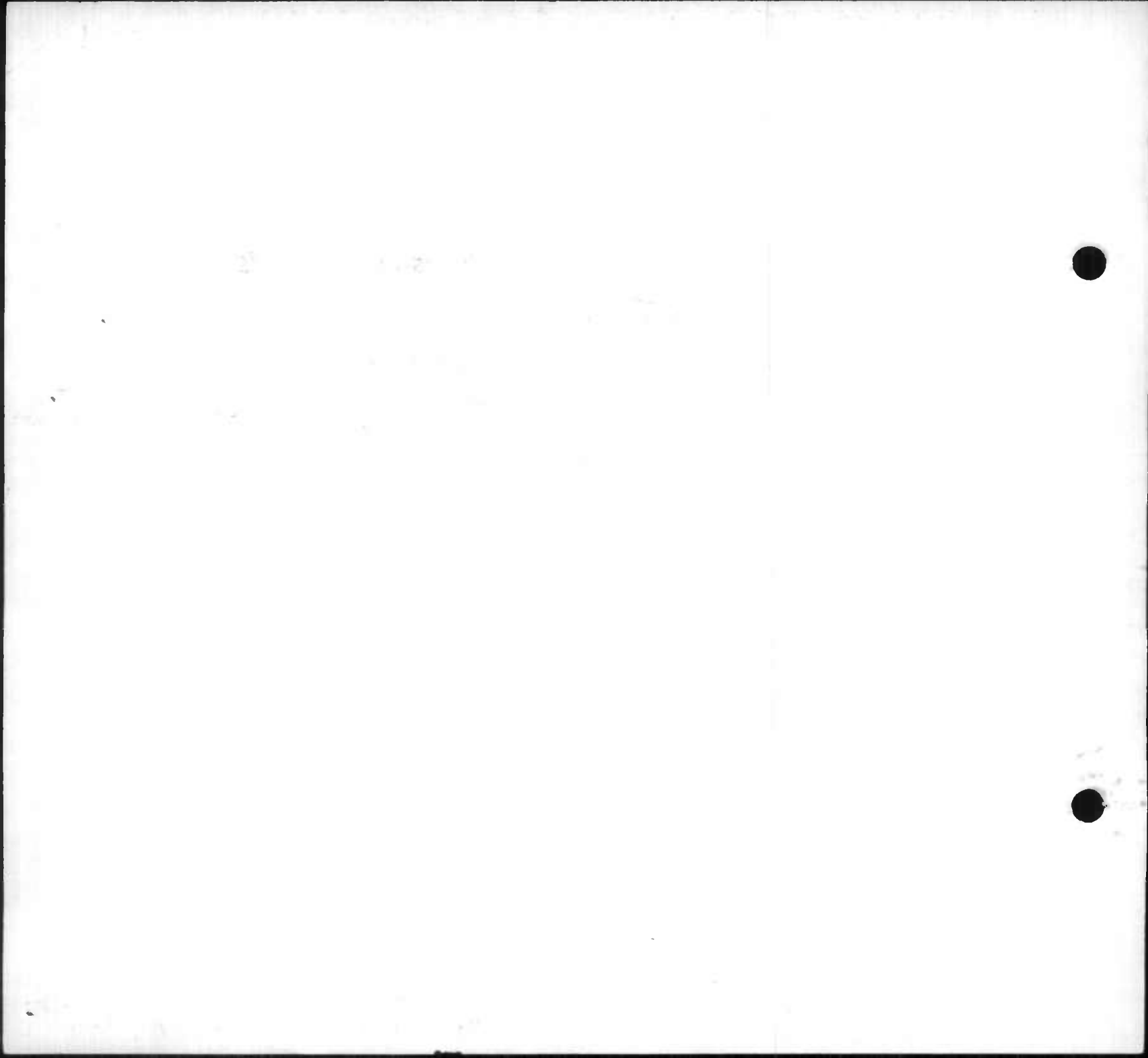
1. NAME OF DECEASED (Type or Print) Evelyn Dotson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 24 Year 71 Hour 4:53 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 24 Year 71 Hour 4:53 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1602	
9. DATE OF BIRTH 8-18-1902		10. AGE (in years last birthday) 68	
11. BIRTHPLACE (State or foreign country) N. Thunderland Co, Va.		12. CITIZEN OF U. S. A.	
13. FATHER'S NAME Jerry Knutt		14. MOTHER'S MAIDEN NAME Elizabeth Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-4645	
17. INFORMANT Delno Dotson		18. ADDRESS 911 Stricker St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-28-71	
24C. NAME of CEMETERY or CREMATORY Arbutus Memeorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

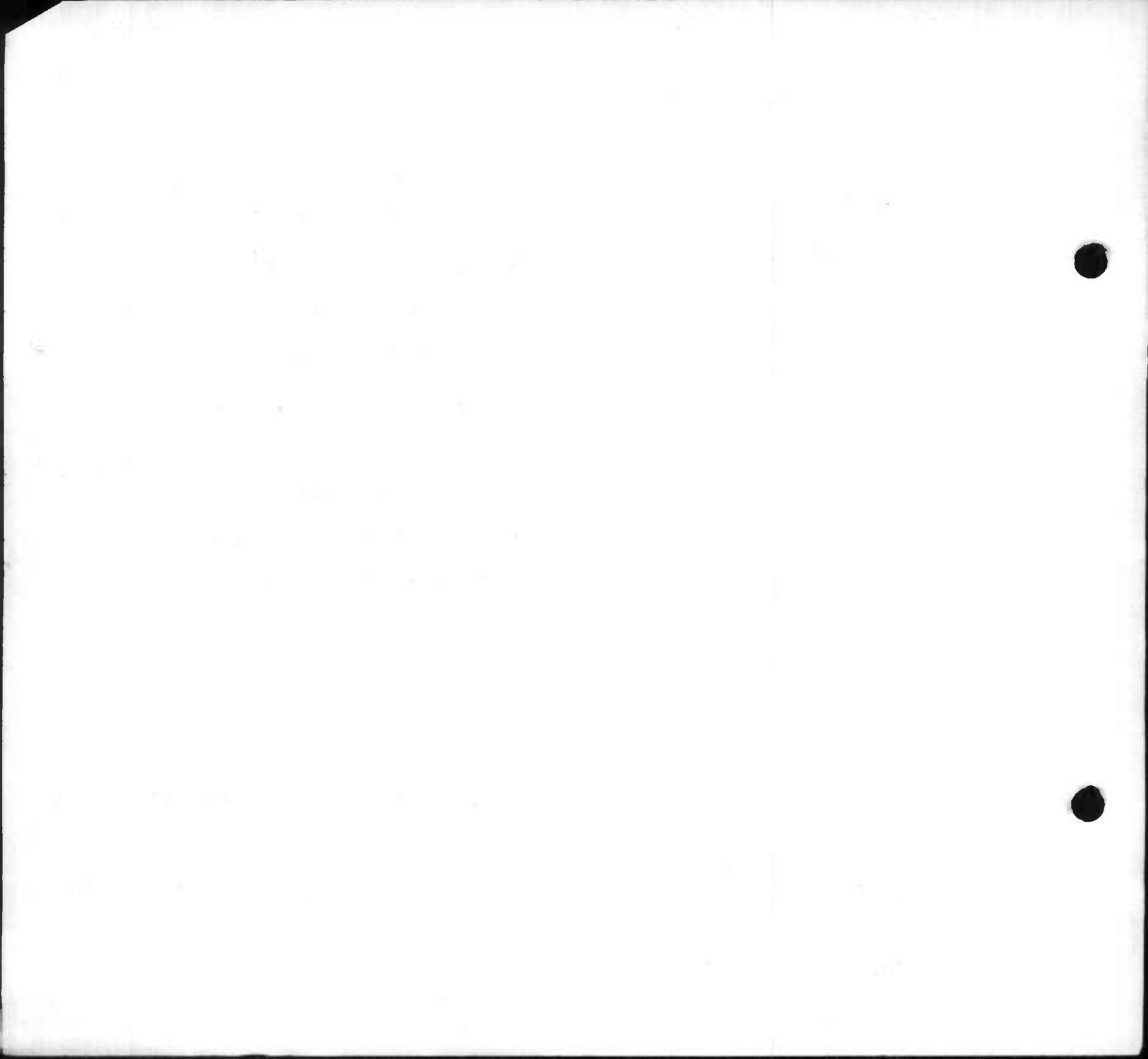
W-452 71 8994		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 8994	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAMES WILLIAMS		9/22/71 7:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE		
			B. COUNTY		
NORTH CHARLES GENERAL HOSPITAL			MARYLAND		5300
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			315 Inside Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
M	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-15-1895	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Retired		VIRGINIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
UNKNOWN			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Brenda Lynn Daye - 5353 James Town	
18. CAUSE OF DEATH			ADDRESS		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			CEREBROVASCULAR accident		UNKNOWN
			(B) ARTERIOSCLEROTIC HEART DISEASE		YEARS
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/22/71 to 9/22/71 that (I) (we) lost saw the deceased alive on 9/22/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
VENERACION			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		9/22/71
			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial			9-25-71		MT. Auburn Cemetery Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
SEP 27 1971			Robert E. Jaber, M.D.		Walter Dyett Pitt 1701 - Laurel



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

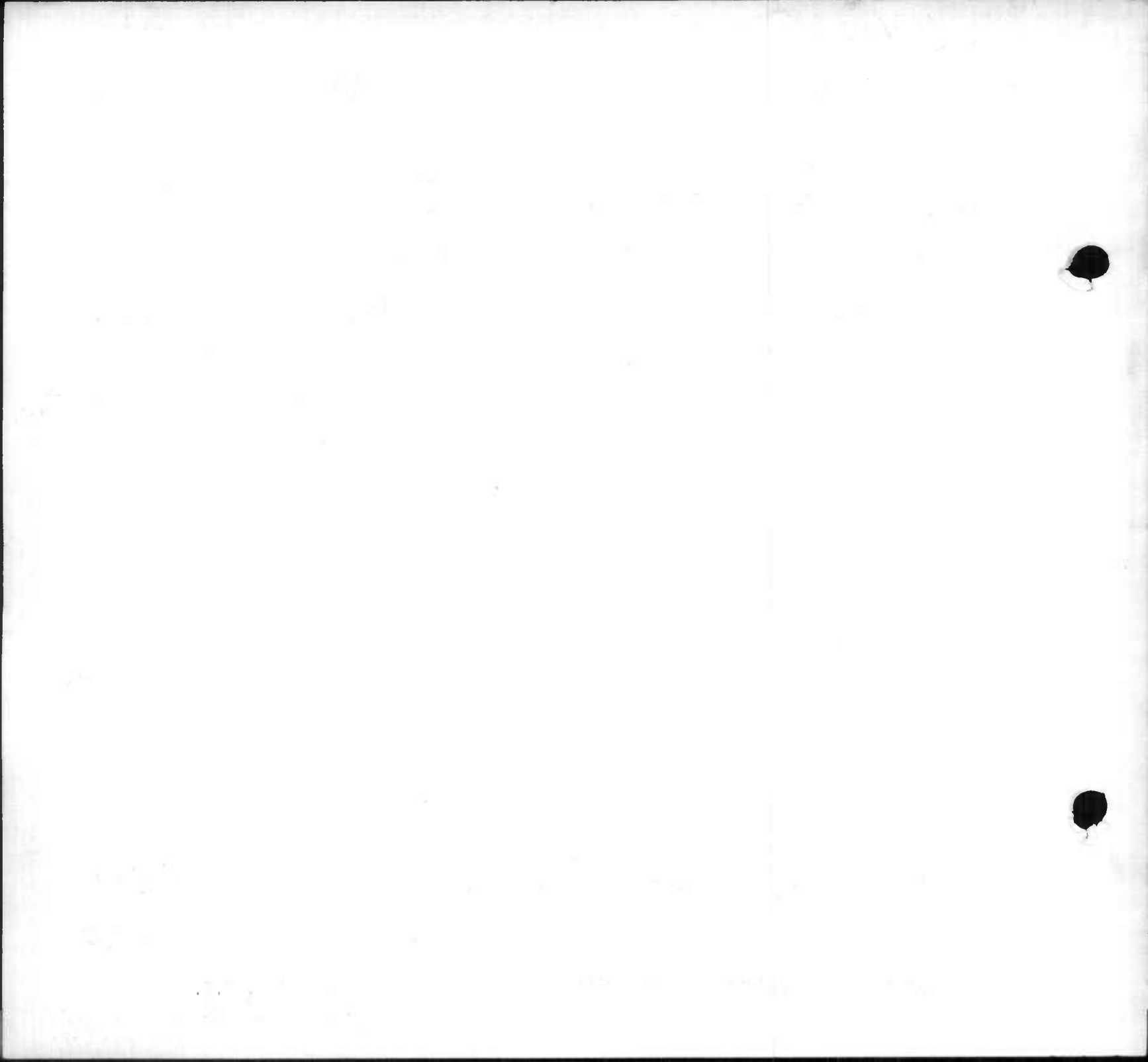
C-600 71 8895		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 8895	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Carey, Fanny</u>		2. DATE AND HOUR OF DEATH <u>Sept 24, 1971 5²⁶ P</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1901</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>205 N. Mount St</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/20/10</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Womack</u>		14. MOTHER'S MAIDEN NAME <u>Josephine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr Harry Wilson, Same</u>	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Disseminated Intravascular Coag</u> <u>Pneumonia</u> (B) <u>Chronic liver Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Alcoholism</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 22</u> 19 <u>71</u> to <u>Sept 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence Hills</u>		DEGREE Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/24/71</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Calvary Cemetery</u>	
24D. LOCATION <u>A A County Md</u>		24E. ADDRESS <u>1206 W north Ave</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Edna E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 8996	
BIRTH NO. 11-400 71 8996							
1. NAME OF DECEASED (Type or Print) EDNA WOOLLEY				2. DATE AND HOUR OF DEATH 9/18/71 2:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS HOSPITAL Wyman Pk. Drive & 31 st St.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE NY 8. COUNTY V-29 C. CITY OR TOWN CALLICOON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BOX 365			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/08	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME HARRY GUTH MULLER			14. MOTHER'S MAIDEN NAME Christine Mayer				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 103 32 5786		17. INFORMANT ADDRESS Records - USPHS Hosp Balto md.		
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Reticulum Cell SARCOMA with metastases to Lung, Liver, Retroperitoneum, Spleen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. J. O'Connell, M.D. FOR Dr. Robert Kinchen				23B. DATE SIGNED 9/19/71		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9/21/71		24C. NAME OF CEMETERY or CREMATORY Hortonville Cemetery	
24D. LOCATION Hortonville, N.Y.				25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			
25B. NAME OF REGISTRAR Robert E. Kinchen				25C. FUNERAL DIRECTOR Robert E. Kinchen			



FUNERAL DIRECTOR: IMPORTANT

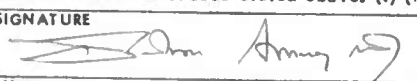
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

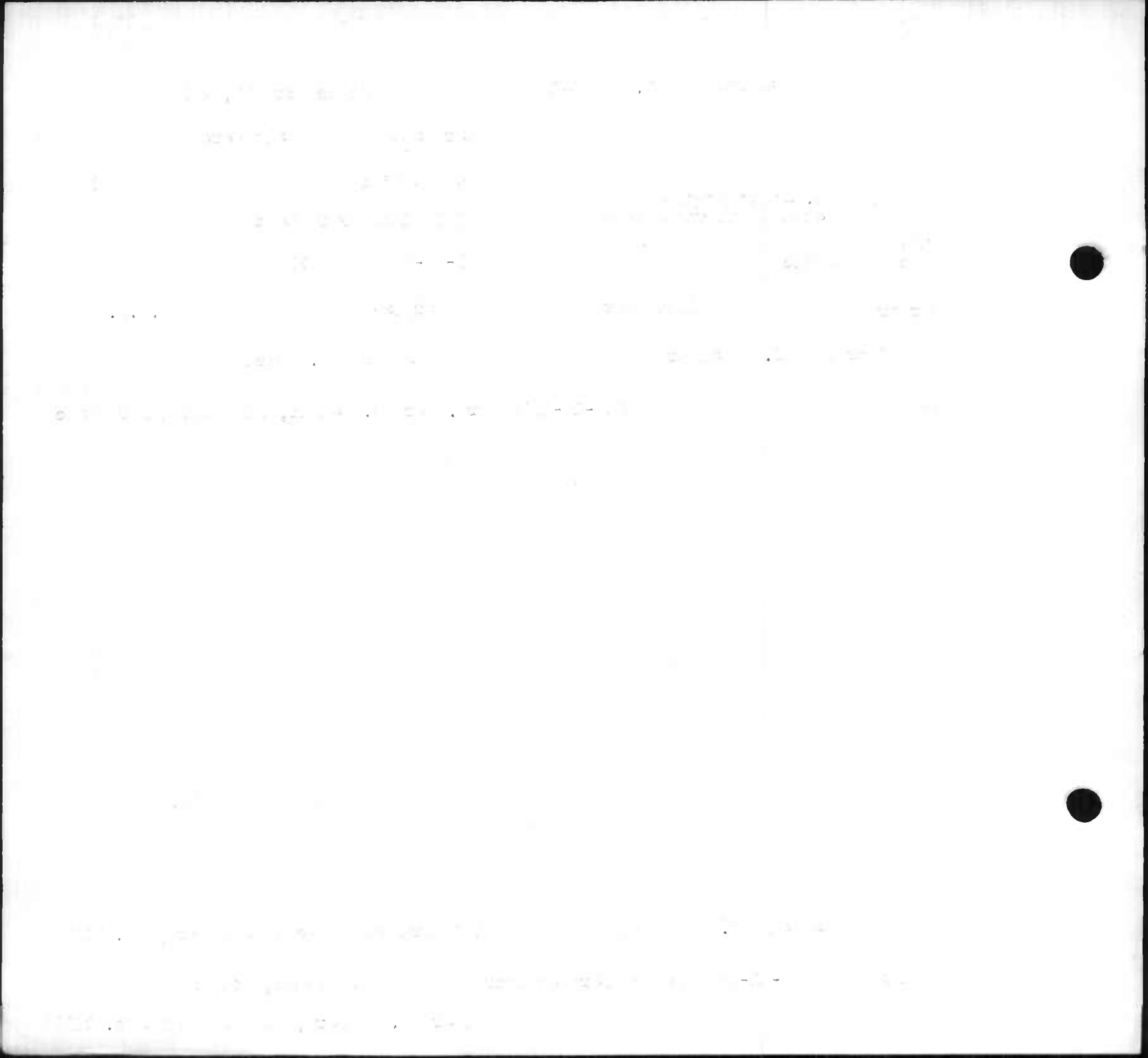
<p>7-632 71 8997</p> <p>BIRTH NO.</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 8997</p>	
<p>1. NAME OF DECEASED (Type in Print) FREITAG, CARRIE ELIZABETH ETTA</p>			<p>2. DATE AND HOUR OF DEATH SEPTEMBER 21, 1971 3:00A M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL</p>		
<p>5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p>8. DATE OF BIRTH 03 18 99 9. AGE Un years 72 lost birthday</p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>			<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		
<p>10B. KIND OF BUSINESS OR INDUSTRY None</p>			<p>12. CITIZEN OF WHAT COUNTRY USA</p>		
<p>13. FATHER'S NAME JOSEPH F. WHEELER DEC 'D</p>			<p>14. MOTHER'S MAIDEN NAME (HESS) FLORENCE DEC 'D</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>			<p>16. SOCIAL SECURITY NO. 216-32-3487-B</p>		
<p>17. INFORMANT RECORD 'S BALTIMORE ADDRESS 21229 ST AGNES HOSPITAL WILKENS & CATON AVE</p>			<p>18. CAUSE OF DEATH</p>		
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) cardiac infarction</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ± 3 hours</p>		
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II</p>			<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: any edema</p>		
<p>(B) DUE TO, OR AS A CONSEQUENCE OF: + infection</p>			<p>+ 4 weeks</p>		
<p>(C) Bad general condition</p>			<p>1 year</p>		
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 27 Mol</p>					
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) YES</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 13, 19 71 to SEPTEMBER 21 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 21, 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (XXX) view the body after death.</p>					
<p>23A. SIGNATURE 27. Mol</p>				<p>23B. DATE SIGNED 09 21 71</p>	
<p>23C. PHYSICIAN'S NAME (Type) J. J. Mol</p>				<p>23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 9/24/71</p>		<p>24C. NAME OF CEMETERY or CREMATORY Christ Episcopal</p>	
<p>24D. LOCATION (City, town, or county) (State) Gulfard Md.</p>		<p>25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971 25B. NAME OF REGISTRAR J. J. Mol 25C. FUNERAL DIRECTOR J. J. Mol ADDRESS J. J. Mol</p>			

2/17/72- Social Security card for Carrie E. Freitag. Claim number 216-32-3487-B.
Birth certificate for Carrie Etta Wheeler. Born: 3/18/1899 at near Jessup.
County of Howard. Date filed: 1899.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-260 71 8998		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	REG. NO. 71 8998
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			GEORGE R. ZAISER		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenues			September 22, 1971		
			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
A. STATE Maryland			B. COUNTY Baltimore		
			C. CITY OR TOWN Catonsville		
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			E. STREET AND NUMBER 717 Wilton Farm Lane		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1894	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Wilton Farm	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George J. Zaiser			14. MOTHER'S MAIDEN NAME Annie M. Meeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-18-1820	17. INFORMANT Mrs. Mary G. Zaiser, 717 Wilton Farm Lane		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Due to, or as a consequence of: ASHD E OED Post MI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
(B) Due to, or as a consequence of: Years.		(C) Due to, or as a consequence of:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/1/1967 to 9/22/1971 that (I) (we) last saw the deceased alive on 9/20/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. St. Agnes E. Resin.					
23A. SIGNATURE 			23B. DATE SIGNED 9/23/71		
23C. PHYSICIAN'S NAME (Type) Adnan M. Sonmez			23D. ADDRESS 1011 Frederick Road, Baltimore, Md. 21228		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-24-71		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARVEL CRUMP		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 22, 1971		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2706 Southern Avenue		3. DATE PRONOUNCED DEAD Month Day Year September 22, 1971		Hour 12:00 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2733					
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH 4-4-1902	10. AGE (In years last birthday) 69	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddius B. Crump		14. STREET AND NUMBER 2706 Southern Avenue			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		14B. KIND OF BUSINESS OR INDUSTRY Oscar Caplan		15. MOTHER'S MAIDEN NAME Fannie S. Taylor	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-05-8743		18. INFORMANT ADDRESS Mrs. Maude Crump, 1819 East Street 21227	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 23, 1971 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR 2238 C. 438, 438		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 9000	
E-425 71 9000				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Elgin, Elsie A.</u>				2. DATE AND HOUR OF DEATH <u>Sept. 22, 1971</u> <u>10:15 AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5707 Arnhem Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/39</u>	9. AGE (In years last birthday) <u>32</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Joseph Mathison</u>			14. MOTHER'S MAIDEN NAME <u>Elsie Getz</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-36-3390</u>		17. INFORMANT <u>Mr. C. Wesley Elgin, 5707 Arnhem Rd. 21206</u>		
18. <u>16211</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio Respiratory Arrest</u> <u>5 min</u>			
				(B) <u>Metastatic Carcinoma of Lung</u> <u>6 months</u>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 21</u> 19 <u>71</u> to <u>Sept. 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10:00 AM Sept. 22</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Barry Cooper MD</u>				23B. DATE SIGNED <u>9/22/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>Barry Cooper, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-25-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Barry Cooper</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			

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513-36-3320